Montana State Level Registry for Provider Incentive Payments

Eligible Hospital User Manual

State Level Registry for Provider Incentive Payments

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Version 3.1

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Introduction

The overall goal of the User Manual is to help guide hospital administrators through the process of completing their State's application for the Centers for Medicare & Medicaid Management's (CMS's) EHR Incentive Payment. This application is submitted through the Montana State Level Registry (SLR), a web tool designed to capture all information needed for the approval of the EHR payment, and to submit the application to your State.

SLR Application Availability

The SLR application is on the Web and is available 24 hours a day, 7 days a week and is accessible from the internet.

Problem Reporting

For general Help, all SLR web pages have a **Help** Link that opens up a copy of this User Manual. For SLR Web application assistance, you can contact the ACS Help Desk designated to support the SLR.

Phone: (866) 879-0109
Email: SLRHelpdesk@acs-inc.com

For questions about the Montana EHR incentive payment program, contact a Montana representative:

Email: MedicaidEHR@mt.gov
http://medicaidprovider.hhs.mt.gov/providerpages/ehrincentives.shtml

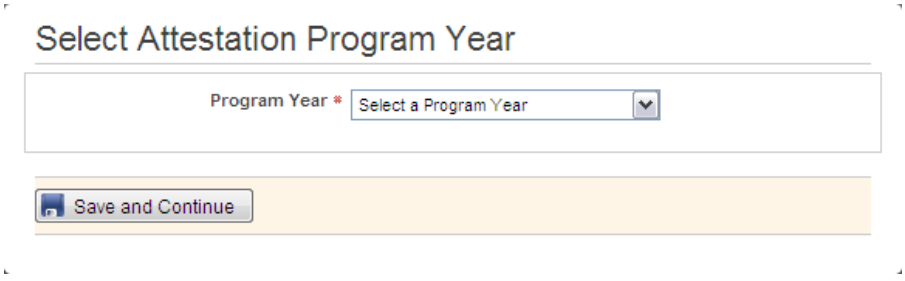
Overview

As the healthcare landscape continues to modernize, legislation was passed to encourage the adoption of Electronic Health Record (EHR) technology in documenting patient care. Because of the American Recovery and Reinvestment Act (ARRA) of 2009, eligible Medicaid Providers are being offered financial incentives for the implementation and meaningful use of Health Information Technology (HIT) in the management of patient populations. In support of this initiative, ACS has developed the EHR Provider Incentive Portal application, called the State Level Registry (SLR).

By using SLR, you have access to a streamlined application for federally funded HIT incentives through an easy-to-use website. With self-service flexibility, you can move through registration, eligibility and attestation at your own pace while the SLR application stores your information in an organized manner. This application provides the most direct path to your incentive payment.

Dates

An EH applying for 2014 program year must have Medicaid eligibility dates between 10/1/12 – 9/30/13. EHs starting their applications after January 1, 2014 will be in the 2014 program year. Each State has a designated Grace Period in the beginning of the year during which users that have not submitted an Attestation Agreement can elect the year for which they are Attesting. Users can select the current year and submit Eligibility numbers for the previous fiscal year, or select the previous year as their Program Year and enter numbers from the year before that.



Application Architecture

The SLR Web application features the following:

- Compliance with Section 508 accessibility guidelines.
- Accessibility from the internet: ACS has made every effort to make this site accessible to people with disabilities. In the event you experience difficulty accessing this site with assistive devices, please contact our Help Desk at (866) 879-0109 for assistance in obtaining the information you need.
- Secure protected page access.

Materials and Preparations

Materials the user will need to use the software:

- Computers with access to the web browser.
- Software – **Adobe Acrobat Reader –** installed on your machine to view PDF files.
- The Pop-up Blocker feature of your browser should be set to **Off** to enable pop-up window features.
- Manuals and/or FAQ's that are available for distribution.

Also note that this application is approved for use with Microsoft Internet Explorer versions 7.0 and 8.0.

Method

Login – Accessing the SLR

The SLR is a web-based application. It is accessible from the internet via the Provider Outreach Web portal or directly from a login URL.

1. Open Microsoft Internet Explorer to access the Web.
2. Type your State's URL in the address field and press the **Enter** key on your keyboard.

https://mt.arraincentive.com

SLR login from the Provider Outreach Web portal.

You can access the SLR Web application from the Provider Outreach Web portal. This webpage features provider education resources related to the American Reinvestment and Recovery Act (ARRA) and the Health Information Technology for Economic and Clinical Health (HITECH) act, and also provides a link to the SLR application login page.

The *Provider Outreach* page displays the following:

1. Montana banner section. Located at the top of the page, the banner displays the following items that are visible on every page of the SLR application:
    a. Client logo and tagline. This is the Montana Department of Public Health and Human Services logo and with SLR tagline.
    b. SLR heading "Montana Medicaid State Level Registry for Provider Incentive Payments". This is the name of the application.
    c. **Provider Outreach Home** link: Clicking this link returns you to the *Provider Outreach (Home)* page.
    d. **Contact Us** link: Clicking this link opens a pop-up page displaying contact information consisting of the ACS Help Desk phone number and email.
2. SLR Account Creation/Entry, FAQs and RSS Feeds sections. Located to the left and right of the page, these columns display the following sections:
    a. *Deadlines for Calendar Year 2011 Montana Medicaid EHR Incentive Payment Applications* section: contains links to information for both eligible professionals and eligible hospitals.
    b. *Need to create an SLR account?* section: clicking the **leave this site and create an SLR account** link directs you to the *Create Account* page.
    c. *Already have an SLR account?* section: Clicking the **go directly to the State Level Registry for Provider Incentive Payments** link directs you to the *Login* page.
    d. *Centers for Medicare & Medicaid Services (CMS)* section: clicking a link in this section opens up a new window and displays an article related to CMS.

e. *EMR and HIPAA* section: clicking a link in this section opens up a new window and displays an article related to one of these healthcare topics.

f. *Are you Eligible?* section: clicking the **Run the CMS Eligibility Wizard** link directs you to a wizard designed by CMS to help you determine basic eligibility to the provider incentive program.

g. *Frequently Asked Questions* section: clicking the **view our list of most frequently asked questions** link directs you to CMS' frequently asked questions website related to electronic health record (EHR) technologies and the incentive program.

h. *Healthcare IT News* section: clicking a link in this section opens up a new window and displays an article related to Healthcare IT news.

3. Primary Page Body Content section. Located in the middle of the page, the primary page content entails the following sections:

   a. Welcome text. This is an overview of the Provider Outreach Web portal.

   b. *Want to get a jump start? Click Here!* section: clicking this link opens up a new window and will guide you through the process of gathering information to complete the SLR, the link to create an account.

   c. *Regional Extension Centers (REC)* section: clicking a link in this section opens up a new window and displays the REC website.

Health Technology Services
REGIONAL EXTENSION CENTER
a division of MOUNTAIN-PACIFIC QUALITY HEALTH
www.htsrec.com • (406) 457-5888

4. *Important Web Resources* section: clicking a link in this section opens up a new window and displays the associated website.

5. Footer section. Located at the bottom of the page, the footer displays the following items:

   a. **Privacy** link: opens the approved Statewide Policy for Internet Privacy and Security in a new window.

   b. **Terms of Use** link: Clicking this link opens a new window with a Terms of Use policy displayed.

   c. **Accessibility** link: Clicking this link opens a new window with the website's Accessibility policy displayed.

   d. ACS/Xerox copyright: this is ACS's copyright symbol and text.

Provider Outreach Home | Contact Us |

Deadlines for Calendar Year 2011 Montana Medicaid EHR Incentive Payment Applications

Registration for Montana Eligible Professionals (EP) and Eligible Hospitals (EH) began on November 7th, 2011. The first year payment is based on the EP/EH attesting to the adoption, implementation, or upgrade (A/I/U) to certified EHR technology. Registration and attestation for a 2011 payment must be made by the dates specified below:

Eligible Professionals
Eligible Hospitals

Need to create an SLR account?

Click here to leave this site and create an SLR account for accessing the Montana Medicaid EHR Incentive Program site.

Already have an SLR account?

Click here to go directly to the State Level Registry for Provider Incentive Payments site.

Centers for Medicare & Medicaid Services (CMS)

Beginning January 3, 2011, the Electronic Health Record (EHR) Information Center will be open to assist the EHR Provider Community with both program and system inquiries from 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays, at 1-888-734-6433 (primary number) or 888-734-6563 (TTY number). more info...

(all links open in new window)

Dec 20, 2011
10,000 People with Medicare Can Get Most Care at Home with Demonstration
Dec 19, 2011
32 Health Systems Ready to Improve Care, Saving up to $1.1 Billion
Dec 15, 2011
Making Care Better: Paying Dialysis Facilities for Performance

EMR and HIPAA

(all links open in new window)

Dec 29, 2011
Top 10 Medical Technology Hazards List – "Top 10" Health IT List Series
Dec 28, 2011
Top Health Industry Issues of 2011 – "Top 10" Health IT List Series
Dec 27, 2011
9 Ways IT is Transforming Healthcare – "Top 10" Health IT List Series

Welcome to the Montana State Level Registry (SLR) — Provider Outreach Page

Montana providers must register with the CMS registration and attestation system, formerly known as NLR, prior to registering with the Montana State Level Registry. The tools in this Provider Outreach Page will help you start collecting and organizing the information you will need in order to register with Montana's SLR.

As the healthcare landscape continues to modernize, recent legislation was passed to encourage the adoption of Electronic Healthcare Record (EHR) technology in documenting patient care. As a result of the American Recovery and Reinvestment Act of 2009, beginning in 2011, eligible Medicaid providers are offered financial incentives for the implementation and meaningful use of Health Information Technology (HIT) in the management of patient populations.

The State of Montana Department of Public Health and Human Services has elected to participate in the HIT incentive program. Our primary goal is to provide an effective means of administering and distributing incentive monies to eligible providers and hospitals, including establishing a process to determine eligibility and track meaningful use. The Department's objectives in this process include:

Click here to view information that will give you a jump start on getting your ARRA incentive payment.

- The implementation of a cost effective, fully automated, and auditable process to administer incentive payments to eligible providers and hospitals,
- Development of incentive program administrative rules designed to maximize the opportunity for Montana Medicaid Providers to participate,
- Diligent oversight of the incentive program including routine audits and quality assurance checks of meaningful use attestations and reporting mechanisms,
- Coordination with community partners to help encourage the adoption of certified EHR technology and the electronic exchange of health care information.

To streamline the process in applying for the incentive and provide supportive resources throughout your HIT transition, this web portal centralizes the national, state and regional links for additional program information. It also serves as the portal to access Montana's State Level Registry (SLR). In support of Montana's vision of this site also offers the following:

- A centralized "one-stop" launching pad of available tools for managing your EHR Incentive information
- Organized information offering real-time feeds of current HIT news and updates from other federal organizations.

Educate yourself today on the benefits of HIT and be a part of transforming the quality, efficiency and safety of healthcare delivery.

Regional Extension Centers (REC) (all links open in new window)

Health Technology Services
REGIONAL EXTENSION CENTER
a division of MOUNTAIN-PACIFIC QUALITY HEALTH
www.htsrec.com • (406) 457-5888

The Montana Regional Extension Center is a federally-funded resource that provides technical assistance to help primary care providers with EHR selection and implementation. More information is available here: http://www.htsrec.com.

Important Web Resources (all links open in new window)

- CMS EHR Incentive Program Registration site
- Centers for Medicare & Medicaid Services (CMS)
- ONC Certified Health IT Products

Are You Eligible?

Run the CMS Eligibility Wizard and quickly see if you may qualify for incentive payments.

Frequently Asked Questions

Have a question? Click here to view the CMS list of frequently asked questions.

Healthcare IT News

(all links open in new window)

Dec 29, 2011
Houston HIE goes live
Dec 27, 2011
Hospital achieves MU with VA spinoff
Dec 22, 2011
Feds launch ACO initiative

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To get to the login page from the *Provider Outreach* page, click on the **go directly to the State Level Registry for Provider Incentive Payments** located on the upper left hand corner of the *Provider Outreach* webpage.

Need to create an SLR account?
Need an SLR account?
Click here to leave this site and create an SLR account for accessing the Montana Medicaid EHR Incentive Program site.

Login directly from the SLR login URL

If you have already created an account, you can also get to the SLR's *Login* page by entering the URL into your browser:

https://mt.arraincentive.com/

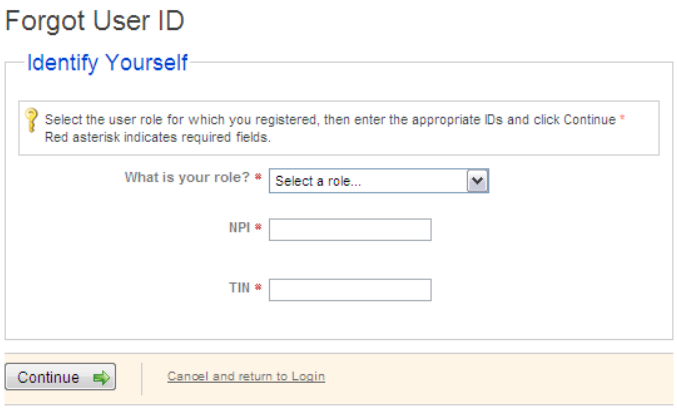
Type the Montana State Level Registry URL in the address field and press the **Enter** key on your keyboard.

From here, you will reach the SLR Web application *Login* page. You'll have three chances to enter in the correct login information before the system locks your account. If that happens, call the Help Desk for assistance.

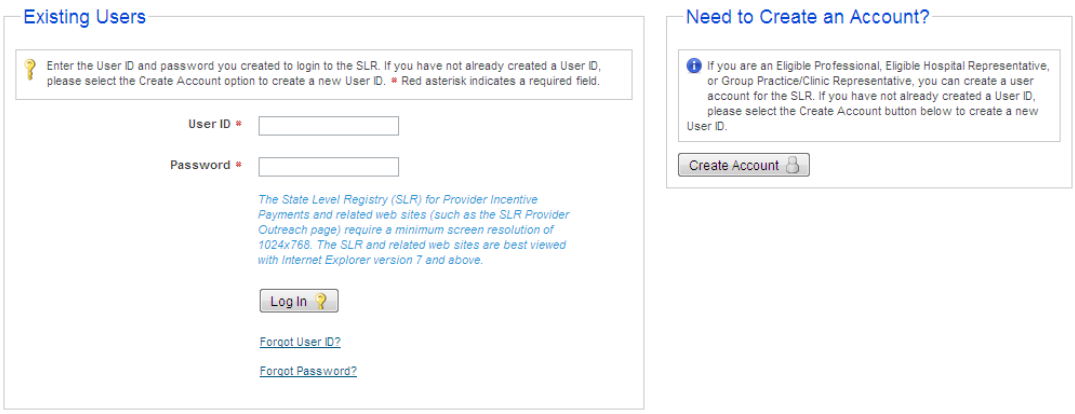
Throughout the SLR application, red asterisks (*) display on various fields. This symbol indicates that this field is required to be completed in order to continue through the application.

The *Login* page displays the following:

1. **User ID** field: enter your User ID.
2. **Password** field: enter your password.
3. **Login** button: verifies the User ID and password you entered and opens the End User License Agreement (EULA).
4. **Forgot User ID?** link: selecting this will open a Forgot User ID pop-up asking you for your National Provider Identifier (NPI) and Tax Identification Number (TIN) as well as the answer to the Challenge Question you selected when you first created the account. Once you have entered those correctly, the system will email the User ID to the email address entered when you created your account.


Forgot User ID
Identify Yourself
Select the user role for which you registered, then enter the appropriate IDs and click Continue *
Red asterisk indicates required fields.
What is your role? *
Select a role...
NPI *
TIN *
Continue
Cancel and return to Login

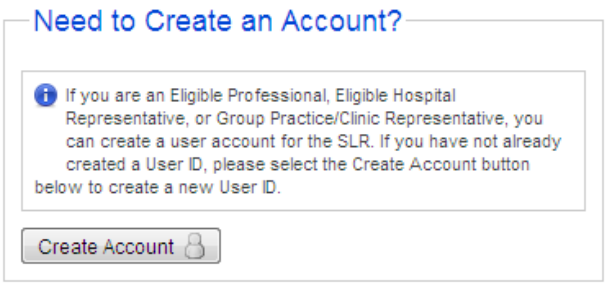
5. **Forgot Password?** link: select when you have forgotten your password. The system will ask you for your User ID as well as the answer to the Challenge Question you picked when creating your account. Once you have entered those correctly, the system will email a link to reset your password to the email address you entered when you created your account.
6. **Create Account** button: select this if you need to create a new SLR account.


Existing Users
Enter the User ID and password you created to login to the SLR. If you have not already created a User ID, please select the Create Account option to create a new User ID. * Red asterisk indicates a required field.
User ID *
Password *
The State Level Registry (SLR) for Provider Incentive Payments and related web sites (such as the SLR Provider Outreach page) require a minimum screen resolution of 1024x768. The SLR and related web sites are best viewed with Internet Explorer version 7 and above.
Log In
Forgot User ID?
Forgot Password?
Need to Create an Account?
If you are an Eligible Professional, Eligible Hospital Representative, or Group Practice/Clinic Representative, you can create a user account for the SLR. If you have not already created a User ID, please select the Create Account button below to create a new User ID.
Create Account

Creating a New SLR Account for Hospital Representatives

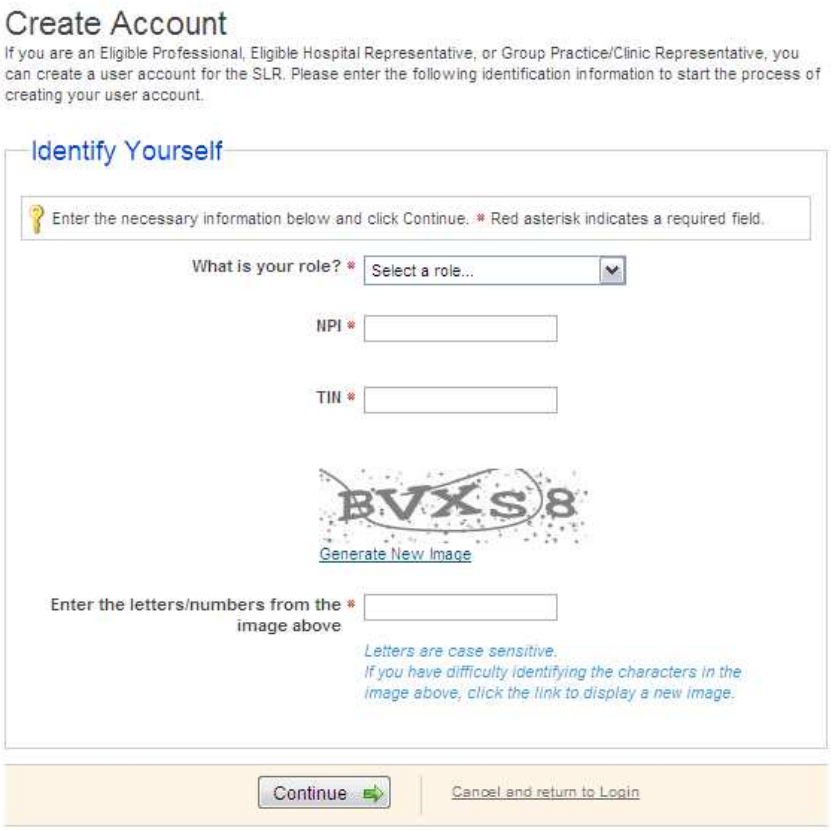
To create a new account from the *Provider Outreach* page, select the **leave this site and create an SLR account** link located on the left side of the *Provider Outreach Jumpstart* page.

To create a new account from the *Login* page, select the **Create Account** button.


Need to Create an Account?
If you are an Eligible Professional, Eligible Hospital Representative, or Group Practice/Clinic Representative, you can create a user account for the SLR. If you have not already created a User ID, please select the Create Account button below to create a new User ID.
Create Account

The *Create Account* page displays the following:

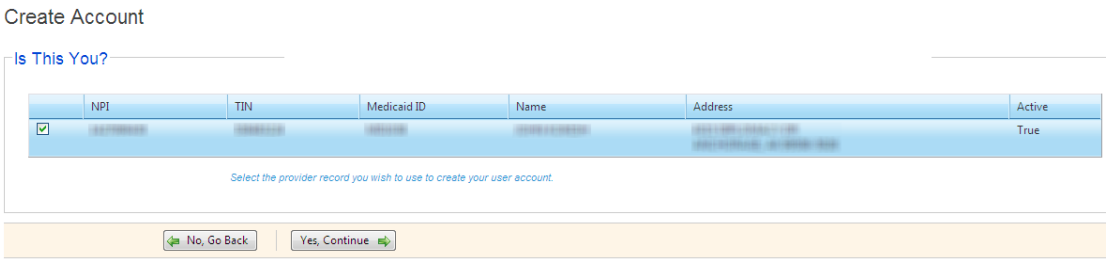
1. **What is your role?** pull-down menu: identify your Provider Type by selecting an option from the menu. As an individual physician or medical professional, select Individual Eligible Professional.
2. **NPI** text field: enter your National Provider Identifier (NPI) number. If you have more then one NPI, use the one that you used while registering with the CMS Medicaid EHR Incentive Program Registration Site. If the number entered is not recognized, an error message will appear, and you will not be able to proceed.
3. **TIN** text field: enter your Taxpayer Identification Number (TIN), which is either your Employer Identification Number (EIN) or your Social Security Number (SSN).
4. **CAPTCHA** image: a computer-generated image.
5. **Generate New Image?** link: refreshes the image above if you are unsure of what numbers and letters are being displayed.
6. **Enter the letters/numbers from the image above** text field: enter the letters and/or numbers you see in the **CAPTCHA** image. This is a security feature.
7. **Continue** button: select this button to open the SLR. You will confirm your name and the address associated with your NPI and TIN.
8. **Cancel and return to Login** link: opens the *Login* page.


Create Account
If you are an Eligible Professional, Eligible Hospital Representative, or Group Practice/Clinic Representative, you can create a user account for the SLR. Please enter the following identification information to start the process of creating your user account.
Identify Yourself
Enter the necessary information below and click Continue. * Red asterisk indicates a required field.
What is your role? *
Select a role...
NPI *
TIN *
BVXS8
Generate New Image
Enter the letters/numbers from the image above *
Letters are case sensitive.
If you have difficulty identifying the characters in the image above, click the link to display a new image.
Continue
Cancel and return to Login

Clicking the **Continue** button opens the next page where you will confirm that the information the system has retrieved up is accurate.

The *Create Account Confirmation* page displays the following:

1. **NPI** display field: the NPI you entered on the *Identify Yourself* page.
2. **TIN** display field: the TIN entered on the *Identify Yourself* page.
3. **Medicaid ID** display field: the Medicaid ID associated with the NPI and TIN you entered.
4. **Name** display field: the name associated with the NPI and TIN you entered.
5. **Address** display field: the address associated with the NPI and TIN you entered.
6. **Active** display field: will display true if the NPI / TIN is active with the state Medicaid program and false if it is inactive.
7. **No, Go back** button: returns to the previous page.
8. **Yes, Continue** button: opens the next page to continue creating your account.



All records that match the NPI or TIN will be displayed, including any records with an inactive status. Only those records with an active status can be used to create an account.

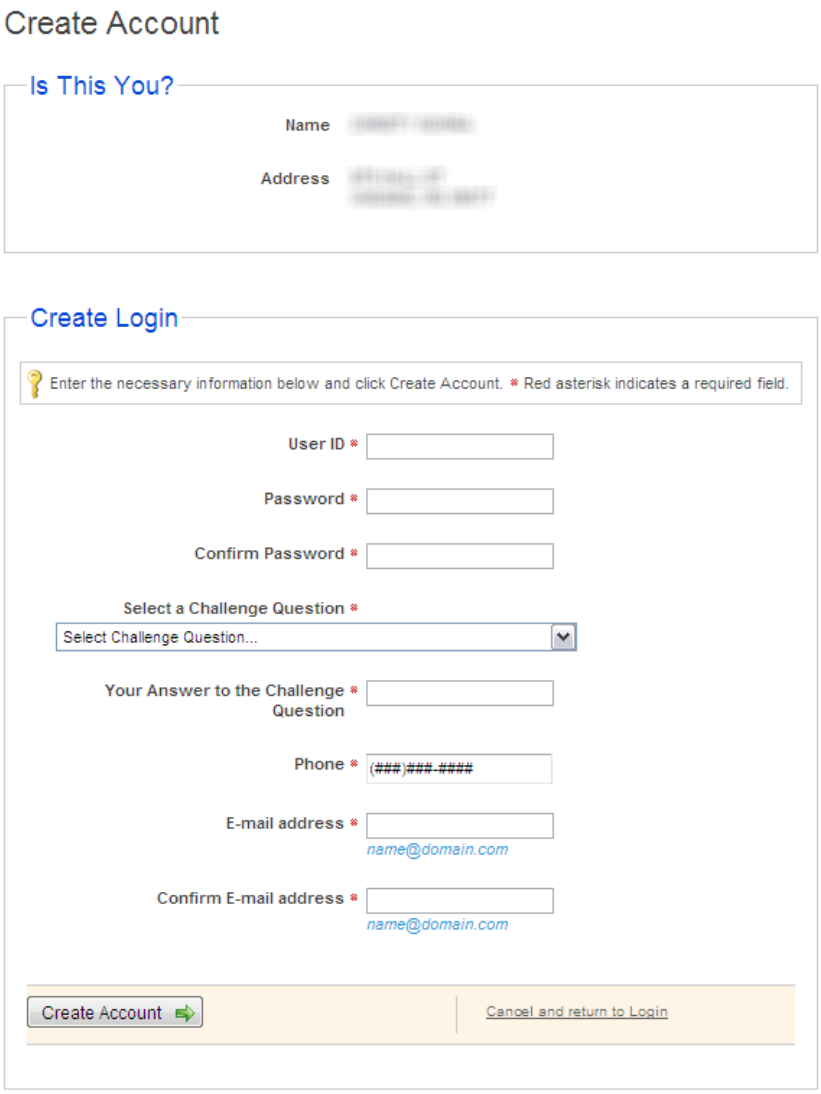
If the information is not correct, select the **No, Go Back** button to return to the previous page. From there, you can either retry entering your NPI and TIN or call the Help Desk for assistance.

If the information is correct and you click the **Yes, Continue** button. The following section will appear on the page:

1. **User ID** text field: enter a User ID Number. This must be at least 8 letters and/or numbers long, but not more than 20 letters and numbers.
2. **Password** text field: enter a password. Your password also needs to be at least 8 letters and numbers long and must be less than 20 letters/numbers. When you are choosing a password, you also need to make sure to include the following:

   - At least one capital letter
   - At least one lower case letter
   - At least one number
   - At least one of the following special characters: @ or # or !

   Your password cannot be your User ID or your User ID spelled backwards.
3. **Confirm Password** text field: enter the password you entered above to confirm it.
4. **Select a Challenge Question** pull-down menu: select an option from the pull-down menu as a Challenge Question to answer.
5. **Your answer to the Question** text field: enter an answer for the Challenge Question that you selected above. You'll need this information if ever forget your User ID or password.
6. **Phone Number** text field: enter your phone number as a ten-digit number, with no spaces, dashes, or parentheses.
7. **Email Address** text field: enter your email address.
8. **Confirm Email Address** text field: enter your email address again to ensure it was not misspelled.
9. **Create Account** button: select this button to save your account. If you left a required field blank or entered information incorrectly, you will receive an error message.
10. **Cancel and return to Login** link: select this button to cancel all the changes and return to the *Login* page.



Once you click the **Create Account** button, you will be routed to the final page for creating an account.

The final *Create Account* page displays the following:

1. **Account successfully created** display message: signifies that you have successfully created your SLR account.
2. **Continue to Login** button: opens the Login page.

Accepting the End User License Agreement (EULA)

After your first login to the system, you will be presented with the End User License Agreement (EULA). You must read and agree with the EULA in order to continue.

The *End User License Agreement* page displays the following:

1. **I Agree with the End User License Agreement** checkbox: selecting this checkbox indicates that you agree with the associated statement.
2. **Print EULA** link: clicking this link will open a new window containing a printable version of the EULA. A *Print* window will also open.
3. **Continue** button: opens the SLR home page.
4. **Cancel and return to Log in** link: returns you to the *Login* page.

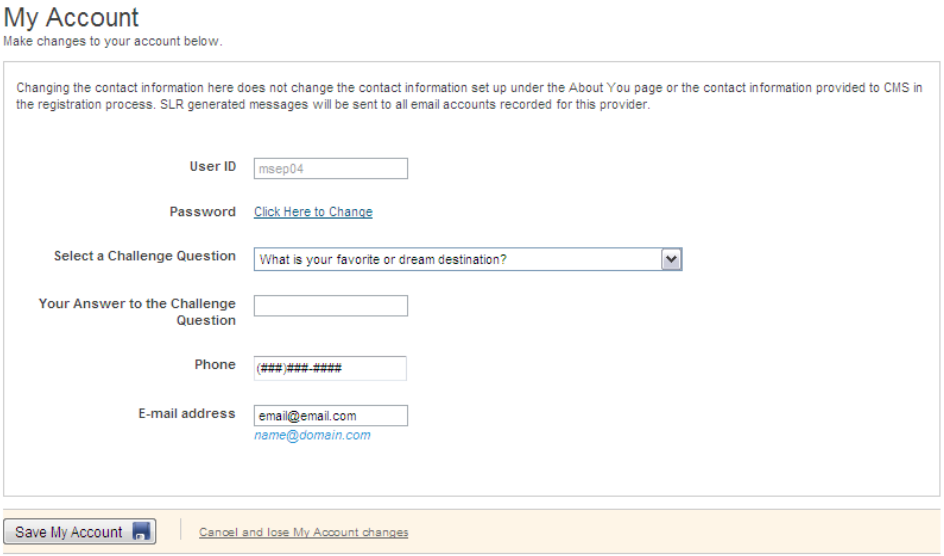
Changing Your Password

Your password will be effective for 60 days. When you log in and 60 days have passed since you created the previous password, a *Reset Password* page will appear. You can change your password on this page.

1. After 60 days, the *Reset Password* page displays:
    a. **New Password** text field: enter a new password.
    b. **Confirm New Password** text field: enter the password again.
    c. **Save** button: selecting this button saves your new password.
    d. **Cancel** button: clears entries made into the two text fields above, and no change is made to your password.
2. Voluntary Password Change.
    To change your password before the 60 days have passed, select the **My Account** link in the top right-hand corner of the SLR *Home* page. In addition to changing your password, you can also update contact information or change your Challenge Question or answer on this page.

    The *My Account* page displays the following:

    a. **User ID** text field: displays your current User ID and allows you to change it.
    b. **Password** link: select the **Click Here to Change** link to open the *Change Password* page.
        1. **Current Password** text field: enter your current password in this field.
        2. **New Password** text field: enter a new password.
        3. **Confirm New Password** text field: enter the new password to confirm it in this field.
        4. **Change Password** button: click this to change the password and open the *My Account* page.
        5. **Cancel and return to My Account** link: opens the *My Account* page without making a change.
    c. **Select a Challenge Question** pull-down menu: select a new Challenge Question.
    d. **Your Answer to the Challenge Question** text field: if you select a new Challenge Question, enter a new answer to the Question.
    e. **Phone** text field: displays your current phone number and allows you to change it.
    f. **Email Address** text field: displays your current email address and allows you to change it.
    g. **Save My Account** button: saves any updated information you entered on this page.
    h. **Cancel and lose My Account changes** link: clears the information you have entered.


My Account
Make changes to your account below.
Changing the contact information here does not change the contact information set up under the About You page or the contact information provided to CMS in the registration process. SLR generated messages will be sent to all email accounts recorded for this provider.
User ID
msep04
Password
Click Here to Change
Select a Challenge Question
What is your favorite or dream destination?
Your Answer to the Challenge Question
Phone
(###)###-####
E-mail address
email@email.com
name@domain.com
Save My Account
Cancel and lose My Account changes

Navigating SLR

Hard and Soft Stops

Certain fields are required to be populated, like the **Contact Person Name** field on the *Step 1. About You* page. Other fields are both required to be populated and checked against another system to ensure they are correct, such as the **EHR Certification Numbe**r field on the *EHR Certification* page. The State decides whether required fields are hard or soft stops.

- **Hard Stop:** the system will not allow the user to proceed to the next step without populating the field, and having it validated correctly if necessary. The information on the page cannot be saved until the field is populated correctly.
- **Soft Stop:** the user may proceed and enter other information in the system, though the field is still required and must be completed before the user can proceed to *Step 4*. A warning message will be displayed on the page and an icon will be visible in the Navigation Menu. At *Step 4*, the Attestation Agreement is produced, and at this point all required fields must be completed before it can be generated.

Save and Continue

SLR pages that require data entry have a **Save & Continue** button

. When this is selected, measures entered onto certain pages are validated. For example, the **Total (Medicaid) Encounters** entry must be 30% of the **Total Encounters** entry on the *Confirm Eligibility* page.

Only the **Save & Continue** button will validate that the information in required fields is correct and save the results to the database. Using any other kind of navigation – the **Back** button on your browser or links in the *Navigation Menu*, for example – will abandon the page and the entries will not be saved.

Navigation Bar

In Version 2 of SLR, moving through the site is assisted by the use of a *Navigation Menu* on the left-hand side of SLR pages, though it does not appear on the *Home* page. Only links to pages that are available to be accessed will be active in the *Navigation Menu*. Inactive links appear light gray in color, while active links are blue.

Icons appear next to the page links that indicate the status of each page and section in SLR – whether it is complete (), has generated an error notice (), or a required field or task was left undone (). Click the expend icon to view all the submenu items. Click the collapse icon to hide the submenu items.

If the user elects to attest to the Meaningful Use (MU) of their EHR Technology solution, MU Objective and CQM (Clinical Quality Measure) links will appear in the *Navigation Menu*. If the user attests to the Adoption, Implementation, or Upgrade (AIU) of the EHR Technology solution, the *AIU Method* and *EHR Certification* page links will appear.

In the example above, the provider has completed Steps 1 and 2 and is now at Step 3. A required field has not been completed. A hard stop will prevent the page from being saved.

After you log in as an Eligible Hospital (EH) user and accept the EULA, the EH *Home* page will open. The home page serves as a dashboard and navigation tool for the SLR application.

Applying for the Incentive as an Eligible Hospital (EH)

When you log in as an Eligible Hospital (EH) user, you will reach the EH *Home* page. The *Home* page serves as a dashboard and navigation tool for the SLR application.

Home Page

The SLR *Home* page for EHs displays the following:

1. Banner section. Located at the top of the page, the banner displays the following items that are visible on every page of the SLR application:
    a. Montana's Department of Public Health & Human Service logo and tagline.
    b. SLR heading “Montana State Level Registry for Provider Incentive Payments”. This is the name of the application.
    c. **My Account** link: opens the *My Account* page.
    d. **Help** link: displays a PDF copy of this User Manual.
    e. **Contact Us** link: a pop-up page displaying contact information, including the ACS Help Desk phone number and email address.
    f. **Logout** link: allows you to log out of the SLR Web application.
    g. **Filing as Eligible Hospital Representative** message: designates your Provider Type.
    h. Hospital Name display field: the name of the hospital for which you will be completing the information.
    i. Hospital Street Address display field: the street address of the hospital for which you will be completing the information.
    j. Hospital City, State and Zip code display field: the city, state and zip code of the hospital for which you will be completing the information.
1. **Welcome, {Hospital Name}** display field: the name of the hospital you are representing.
2. *Next Steps* section. Located to the left of the page, the *Next Steps* section displays messages:
    a. **Begin/Continue/Complete your Year X submission!** message: displays the year of attestation you are currently completing.
    b. **Section** link: communicates the next page in the process that must be completed.
    c. CMS Message display field: this will display “Data has/has not been received from the CMS Medicaid EHR Incentive Program Registration site”, which indicates whether the SLR application has received data from the CMS.
        i. **View CMS Medicaid EHR Incentive Program Registration Data** link: opens a pop-up window that displays your CMS record.

3. *Payment Information* section: located on the left of the home page, the *Payment* section will display the following items on the *Home* page:
    a. **How your payment is calculated** message: opens a pop-up window that shows your payment for the current year.
    b. **Payment Calculation** message: allows you to check on the status of your payment once your attestation has been submitted.
4. *Reports* section: Located on the left of the home page, the *Reports* section displays the following items when selected:
    a. **Reports** message. you will see the following message when you don't have any data in the system to run a report on: "Reports will be available once your information is saved."
    b. Report Titles: the titles of available reports will appear here. For example, the **Registration and Attestation Summary Report** link will appear after you have saved at least some information in the SLR Web application. Clicking this link opens a pop-up window displaying the report.
5. *Messages* sections. Located to the left side of the home page, the *Messages* section displays the following items:
    a. *Audit* section: provides access to Audit messages.
    b. *Appeals* section: provides access to Appeals messages.
    c. *System Messages* section: provides access to System messages.
    d. Individual messages. Clicking on one of the individual message links will reveal a message.
        i. The first line indicates the window title.
        ii. **Subject** display field:
        iii. **Date Received** display field: the date the message was sent.
        iv. **From** display field: the sender the message.
        v. Message Text section: the message text.
6. *Workflow* section (detailed further below): located to the right of the page, the *Workflow* section displays the following items that are visible on the home page:
    a. Year [x] tabs: each tab represents a year in which you have completed an attestation. The most current year's tab will always be the one visible when you log in. Click other tabs to view a previous year's information.
    a. Sections: each section has a Status icon ( ) that indicates whether each page has been started, whether the page has been completed, or whether it is still locked. A locked page cannot be accessed until the previous pages have been completed. Each section will also have a description. The title of each section provides a link to that section.
        i. **About You**.
        ii. **Confirm Medicaid Eligibility**.
        iii. **Attestation of EHR**. This link will not be active until you've already completed your registration and eligibility.

iv. **Review and Sign Agreement**. This link will not be active until you have completed the Attestation of EHR section.

v. **Send Year {X} Attestation**. This link will not be active until you've reviewed, signed and uploaded your signed attestation agreement. Once you submit the attestation, all of the other sections will be locked for editing and will display your information as view-only.

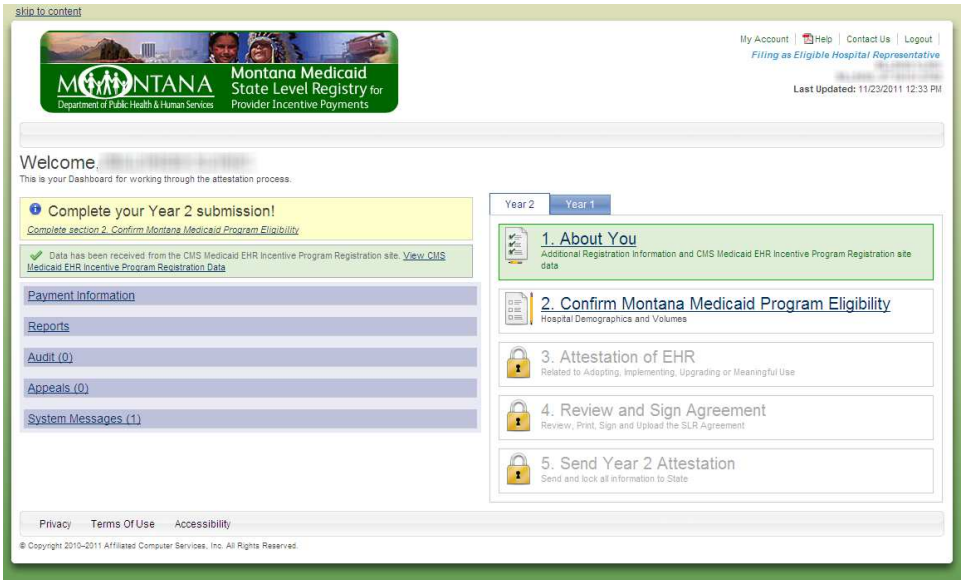
7. Footer section - Located at the bottom of the page, the footer displays the following items:

   a. **Privacy** link: clicking this link opens a new window with a Privacy Statement displayed.

   b. **Terms of Use** link: clicking this link opens a Legal Statement for the site.

   c. **Accessibility** link: clicking this link opens a new window with the website's Accessibility policy displayed.

   a. **ACS/Xerox Copyright.** This is ACS's copy write symbol and text.


skip to content
My Account | Help | Contact Us | Logout
Filing as Eligible Hospital Representative
Last Updated: 11/23/2011 12:33 PM
MONTANA
Department of Public Health & Human Services
Montana Medicaid State Level Registry for Provider Incentive Payments
Welcome,
This is your Dashboard for working through the attestation process.
Complete your Year 2 submission!
Complete section 2. Confirm Montana Medicaid Program Eligibility
Data has been received from the CMS Medicaid EHR Incentive Program Registration site. View CMS Medicaid EHR Incentive Program Registration Data
Payment Information
Reports
Audit (0)
Appeals (0)
System Messages (1)
Year 2
Year 1
1. About You
Additional Registration Information and CMS Medicaid EHR Incentive Program Registration site data
2. Confirm Montana Medicaid Program Eligibility
Hospital Demographics and Volumes
3. Attestation of EHR
Related to Adopting, Implementing, Upgrading or Meaningful Use
4. Review and Sign Agreement
Review, Print, Sign and Upload the SLR Agreement
5. Send Year 2 Attestation
Send and lock all information to State
Privacy
Terms Of Use
Accessibility
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Workflow Section Details

This section describes in more detail the specific steps to take when applying for the Provider incentive. This begins with Step 1, the *About You* section, where you will enter your registration and contact information.

Step 1: About You Section Details

Clicking the **About You** link on the EH *Home* page directs you to the *1. About You* page. This is where you enter your registration information.

The *About You* page displays the following:

1. *CMS Medicaid EHR Incentive Program Registration Record* section

   Please note that it can take up to three day for the SLR to receive your data from the CMS.

a. “Data has not been received from the CMS Medicaid EHR Incentive Program Registration site.” message: this message appears if your data has not been received by SLR.

b. “Data has been received from the CMS Medicaid EHR Incentive Program Registration site.” message: this message appears if the SLR has received your CMS data.

c. **View CMS Medicaid EHR Incentive Program Registration Data** link: this link is visible if your CMS data has been received. Clicking the link opens a pop-up window that displays the CMS data. If you need to make a change to your CMS data, you must make updates on the CMS site. You cannot make changes to your CMS data through SLR, and it takes between two and three days for changes at the CMS level to be applied to SLR.

a. **Visit CMS website** link: opens the CMS website. The link is visible whether or not your data has been received.

2. *Contact Person* section

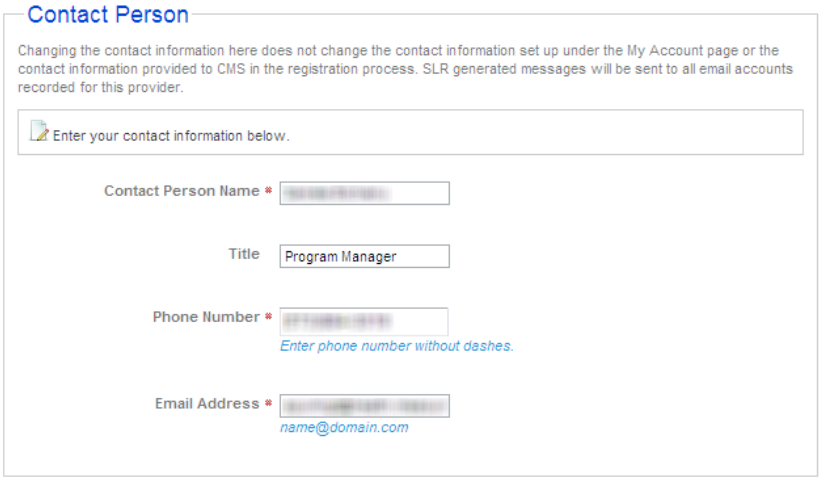
   This allows you to enter an additional contact besides the one listed as the Eligible Hospital user.

   i. **Contact Person Name** text field: enter the name of the contact.

   ii. **Title text** field: enter the title of the individual.

   iii. **Phone Number** text field: enter the phone number as ten digits, with no spaces, dashes, or parentheses.

   iv. **Email Address** text field: enter the contact’s email address. Initially this defaults to the address that was entered when the User Account was first created.


Contact Person
Changing the contact information here does not change the contact information set up under the My Account page or the contact information provided to CMS in the registration process. SLR generated messages will be sent to all email accounts recorded for this provider.
Enter your contact information below.
Contact Person Name *
Title
Program Manager
Phone Number *
Enter phone number without dashes.
Email Address *
name@domain.com

3. **Save & Continue** button: saves the information you entered. If you have left a required field blank or entered information incorrectly, an error message will appear. Once all required fields are completed, this section will be marked as complete. The *2. Confirm Medicaid Eligibility* page will open.

4. **Cancel and lose About You changes** link: clears the page of any information you have just entered and returns you to the *Home* page.

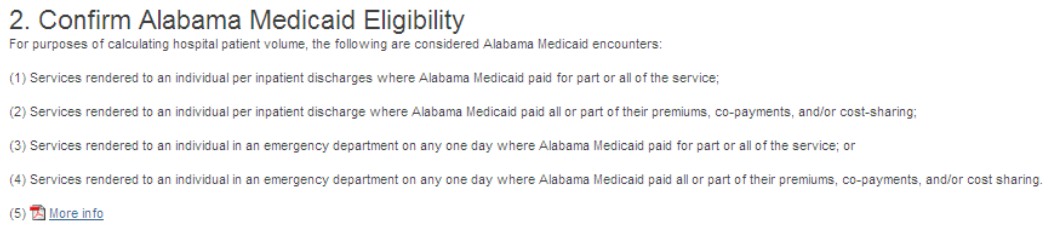
   a. After completing this information, you can proceed to your eligibility information by selecting the **Save & Continue** button. The status icon on

your home page will change to indicate that your registration section is complete. The green background of the first section and the icon indicate that this section has been completed.

Now that you have entered your registration, you can move onto completing your eligibility information by returning to the dashboard and selecting the next step. Also, the status icon on your home page will change to indicate that your registration section is complete.

Step 2: Confirm Medicaid Eligibility Details

Clicking the **Confirm Montana Medicaid Eligibility** link on the EH *Home* page opens the *Confirm Medicaid Eligibility* page, which allows you to enter your Hospital's eligibility information.


2. Confirm Alabama Medicaid Eligibility
For purposes of calculating hospital patient volume, the following are considered Alabama Medicaid encounters:
(1) Services rendered to an individual per inpatient discharges where Alabama Medicaid paid for part or all of the service;
(2) Services rendered to an individual per inpatient discharge where Alabama Medicaid paid all or part of their premiums, co-payments, and/or cost-sharing;
(3) Services rendered to an individual in an emergency department on any one day where Alabama Medicaid paid for part or all of the service; or
(4) Services rendered to an individual in an emergency department on any one day where Alabama Medicaid paid all or part of their premiums, co-payments, and/or cost sharing.
(5) More info

The *Confirm Medicaid Eligibility* page displays the following:

1. **< Back to Dashboard** link: clicking this link will return you to the *Home* page.
2. **Print Registration Attestation** link: opens a PDF document containing all the information you have entered for the Hospital so far in the SLR process.
3. *Medicaid Volume* section.
    a. **Eligibility Completion status** icon: indicates whether your eligibility information is complete or if there is still some missing information on the page.
    b. **Enter Representative Period** pull-down menu: select the appropriate period for patient volumes used in determining the eligibility of the Hospital.
    c. **Year {n} Start Date** field: enter the date of the first day of your representative period. The system will automatically display the end date.
        i. Calendar icon: opens a Calendar Utility from which you can click on a date to select it.
    i. **Year {n} End Date** display field: the end date of the 90-day representative period based on the start date you entered. If you had selected **Other Period** from the **Enter Representative Period** pull-down menu, the end date will be editable.
    j. **Total Discharges for Representative Period** field: enter your total Discharges for the representative period you noted above.
    f. **Do you have Medicaid Patients in more than one State?** radio buttons: identify whether or not you practice in more than one state.
        i. When you select the **Yes** radio button, you must answer the question "Do you want your volumes for all states to be used to determine eligibility?"
        ii. If the answer to this question is also **Yes**, a table will appear allowing you to enter encounters per state.

a. **Do you want your volumes for all states to be used to determine eligibility?** radio buttons: identify whether or not you want to use the other states' volumes to determine your eligibility. If you chose the **Yes** radio button, the *Add a State* component will appear.

b. Select the **Add a State** button to add another row to the table

   i. State pull-down column: select a State to enter the encounter information for that State.

   ii. Total Encounters column: enter the encounters for the State and selected time period.

   iii. Total Medicaid Encounters column

   iv. Total Panel Members column

   v. Total Medicaid Panel Members column

   vi. Insert link: adds the numbers to the multi-State table.

   vii. Cancel link: cancels the operation.

   viii. Remove link. This will remove the associated row.

k. Select the **Add a State** button to add another row to the table.

l. **Total Discharges for a full Fiscal year** field: enter total patient discharges for the previous fiscal year.

m. **Total Patient Bed Days for a full Fiscal year** field: enter total number of bed days for all patients in the previous fiscal year.

n. **Average Length of Stay** display field: the Average Length of Stay for the year of the hospital cost report.

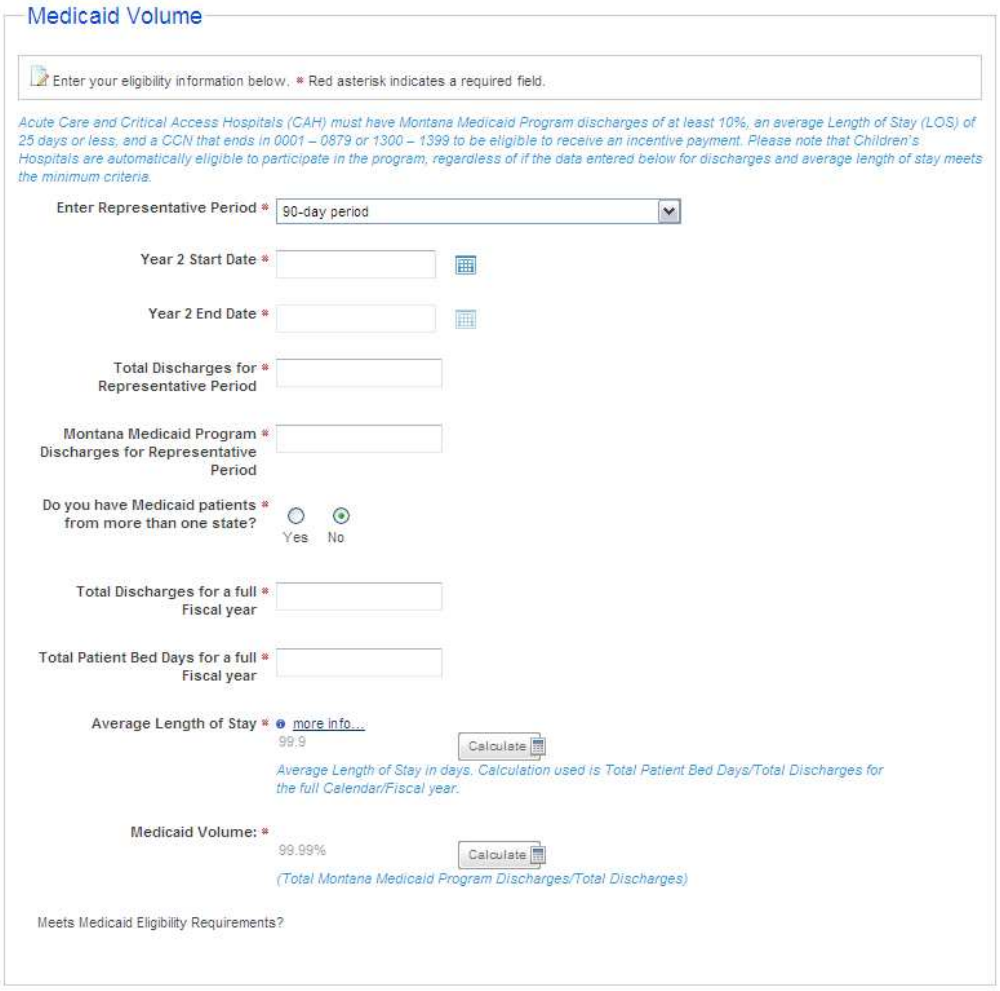
   i. **Calculate** button: calculates the results of Medicaid Volume. The calculated results will be displayed.

   ii. **Display field.** This is where the calculated result is displayed.

o. **Medicaid Volume** section: this formula uses the Total Discharges and Medicaid Discharges to calculate your result.

   i. **Calculate** button: calculates the results of Medicaid Volume. The calculated results will be displayed.

   ii. **Display field.** This is where the calculated result is displayed.


Medicaid Volume
Enter your eligibility information below. * Red asterisk indicates a required field.
Acute Care and Critical Access Hospitals (CAH) must have Montana Medicaid Program discharges of at least 10%, an average Length of Stay (LOS) of 25 days or less, and a CCN that ends in 0001 – 0879 or 1300 – 1399 to be eligible to receive an incentive payment. Please note that Children's Hospitals are automatically eligible to participate in the program, regardless of if the data entered below for discharges and average length of stay meets the minimum criteria.
Enter Representative Period *
90-day period
Year 2 Start Date *
Year 2 End Date *
Total Discharges for Representative Period *
Montana Medicaid Program Discharges for Representative Period *
Do you have Medicaid patients from more than one state? *
Yes
No
Total Discharges for a full Fiscal year *
Total Patient Bed Days for a full Fiscal year *
Average Length of Stay * more info...
99.9
Calculate
Average Length of Stay in days. Calculation used is Total Patient Bed Days/Total Discharges for the full Calendar/Fiscal year.
Medicaid Volume: *
99.99%
Calculate
(Total Montana Medicaid Program Discharges/Total Discharges)
Meets Medicaid Eligibility Requirements?

p. **Meets Medicaid Eligibility Requirements** message: appears if the Calculate button next to the Medicaid Volume display field is selected. It indicates whether you have met the requirements for eligibility.

i. "Yes! Meets Medicaid Eligibility Requirements." will display if your hospital meets the following criteria:

- Your hospital is a Children's Hospital
- Your hospital's Medicaid volume is greater than 10% with an average length of stay less than or equal to 25 days and the last four digits of your CCN are between 00001 through 0879 or 1300 through 1399

ii. "No - you may wish to adjust your representative period…" This message displays when the information entered does not meet the minimum criteria for hospital eligibility. Acute Care and Critical Access Hospitals (CAH) must have Medicaid discharges of at least 10%, an average Length of Stay (LOS) of 25 days or less, and a CCN that ends in 0001 – 0879 or 1300 – 1399 to be eligible to receive an incentive payment. Children's Hospitals with a CCN that ends in 3300 – 3399 are automatically eligible.

4. *Hospital Demographics Information* section.

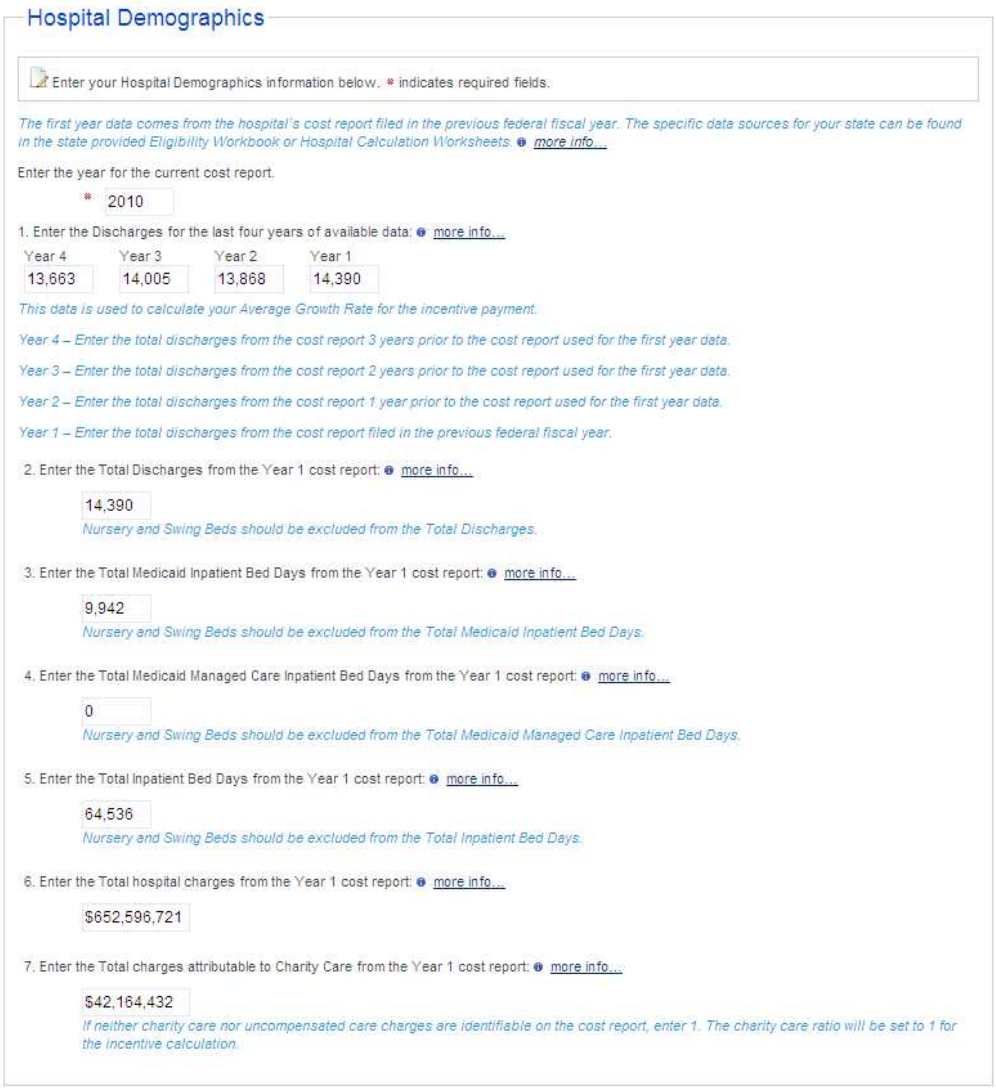
Each of the following fields (or group of fields) has explanatory help text in blue beneath the field, and a **more info** link to help identify what the field is capturing.

a. **Enter the year for the current cost report** field.

b. **Enter the Discharges for the last four years of available data** fields: enter discharges for the last four years in the **Year {x-4}** through **Year {x}** fields.

a. **Enter the Total Discharges from the Year {x} cost report** field.

b. **Enter the Total Medicaid Inpatient Bed Days from the Year {x} cost report** field.


Hospital Demographics
Enter your Hospital Demographics information below. * indicates required fields.
The first year data comes from the hospital's cost report filed in the previous federal fiscal year. The specific data sources for your state can be found in the state provided Eligibility Workbook or Hospital Calculation Worksheets. more info...
Enter the year for the current cost report.
* 2010
1. Enter the Discharges for the last four years of available data: more info...
Year 4 Year 3 Year 2 Year 1
13,663 14,005 13,868 14,390
This data is used to calculate your Average Growth Rate for the incentive payment.
Year 4 – Enter the total discharges from the cost report 3 years prior to the cost report used for the first year data.
Year 3 – Enter the total discharges from the cost report 2 years prior to the cost report used for the first year data.
Year 2 – Enter the total discharges from the cost report 1 year prior to the cost report used for the first year data.
Year 1 – Enter the total discharges from the cost report filed in the previous federal fiscal year.
2. Enter the Total Discharges from the Year 1 cost report: more info...
14,390
Nursery and Swing Beds should be excluded from the Total Discharges.
3. Enter the Total Medicaid Inpatient Bed Days from the Year 1 cost report: more info...
9,942
Nursery and Swing Beds should be excluded from the Total Medicaid Inpatient Bed Days.
4. Enter the Total Medicaid Managed Care Inpatient Bed Days from the Year 1 cost report: more info...
0
Nursery and Swing Beds should be excluded from the Total Medicaid Managed Care Inpatient Bed Days.
5. Enter the Total Inpatient Bed Days from the Year 1 cost report: more info...
64,536
Nursery and Swing Beds should be excluded from the Total Inpatient Bed Days.
6. Enter the Total hospital charges from the Year 1 cost report: more info...
$652,596,721
7. Enter the Total charges attributable to Charity Care from the Year 1 cost report: more info...
$42,164,432
If neither charity care nor uncompensated care charges are identifiable on the cost report, enter 1. The charity care ratio will be set to 1 for the incentive calculation.

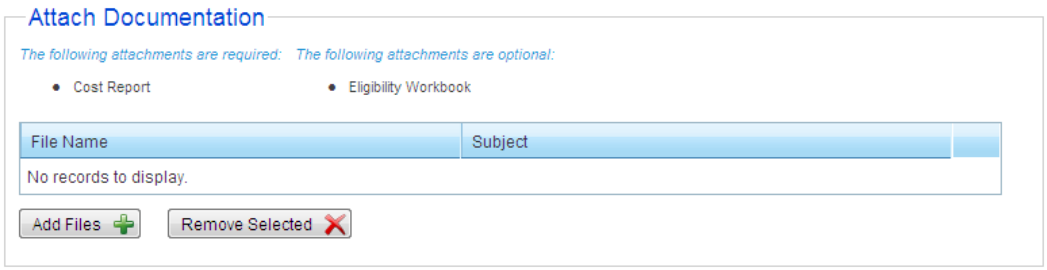
c. **Enter the Total Medicaid Managed Care Inpatient Bed Days from the Year {x} cost report** field.

d. **Enter the Total Inpatient Bed Days from the Year {x} cost report** field.

e. **Enter the Total hospital charges from the Year {x} cost report** field.

f. **Enter the Total charges attributable to Charity Care from the Year {x} cost report** field.

5. *Attach Documentation* section. Montana requires a Cost Report and encourages an Eligibility Workbooks to be attached.



6. **Save & Continue** button: saves the information you have just entered and opens the next page in the SLR process. If you have left required field blank or entered information incorrectly, you will receive an error message.

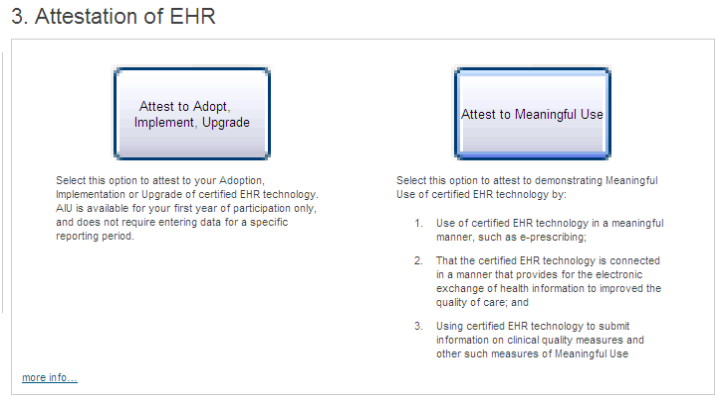
Cancel and lose Medicaid Eligibility changes link: opens the EH *Home* page, saving none of the changes made to fields on the *Confirm Medicaid Eligibility* page.

Step 3: Attestation of EHR Details

EHs may either attest that they have adopted, implemented, or upgraded EHR software, or that they are actively using it in meaningful ways. AIU can only be selected in the first year and is a much easier attestation. Clicking the **Attestation of EHR** link on the EH *Home* page directs you to the *3. Attestation of EHR* page. This lets you select Adopt, Implement, Upgrade (AIU) or Meaningful Use (MU) for your Attestation Type. Once you have selected the Attestation Type, you will then be able to upload documents related to your EHR Software, enter its certification number, and enter other information.

3: Attestation of EHR. The first step of completing this section is to choose the type of attestation. You will be able to access this section once the *About You* and *Confirm Montana Medicaid Eligibility* pages are completed. This page displays the following:

1. **Attest to Adopt, Implement, Upgrade** button: opens the AIU workflow. This option is available only in your first year of participating. This section contains three pages: the *AIU Method* page and the *EHR Certification* page in addition to the *Attestation of EHR* page.
2. **Attest to Meaningful Use** button: opens the MU workflow. This section contains three sections: *Core Objectives*, *Menu Objectives*, and *Clinical Quality Measures*. Each of these sections contains between 10 and 15 pages, though not all of the Menu Objectives are required.


3. Attestation of EHR
Attest to Adopt, Implement, Upgrade
Attest to Meaningful Use
Select this option to attest to your Adoption, Implementation or Upgrade of certified EHR technology. AIU is available for your first year of participation only, and does not require entering data for a specific reporting period.
Select this option to attest to demonstrating Meaningful Use of certified EHR technology by:
1. Use of certified EHR technology in a meaningful manner, such as e-prescribing;
2. That the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improved the quality of care; and
3. Using certified EHR technology to submit information on clinical quality measures and other such measures of Meaningful Use
more info...

Note: if the user has already completed their first year, they must enter MU data and will receive the following message.

Attest To Meaningful Use
Eligible Professionals attesting to Meaningful Use for the first time, need to report Meaningful Use for a 90-day period in the current payment (calendar) year. In this case, the earliest date an Eligible Professional can submit an attestation for Meaningful Use for calendar year 2012 is April 1, 2012. Please return to the site on April 1, 2012 to complete your Meaningful Use attestation.
OK

AIU Method Page

Once the **Attest to Adopt, Implement, Upgrade** button is selected, two new navigation options appear in the Navigation Menu: *AIU Method* and *EHR Certification*. The *AIU Method* page is opened.

This page allows you to choose the method of your AIU attestation and provide any supporting details for that choice.

1. **More info** link: opens a PDF document titled “Attestation of AIU” that explains how documentation would be attached for the selected attestation method.
2. **AIU Method** pull-down menu: select Adopt, Implement, or Upgrade from the menu to best describe your EHR Technology use at this point.
3. **more info** link: opens a pop-up window explaining the type of documentation that needs to be attached for the selected attestation method.
4. **Please describe briefly how you meet…** text area: allows you to describe how you meet the criteria for the AIU method selected.
5. *Supporting Documentation* section: allows the attachment of any supporting documentation encouraged by the State.
6. **Save & Continue** button: selecting this will open the *EHR Certification* page after SLR ensures that all fields on this page are populated.

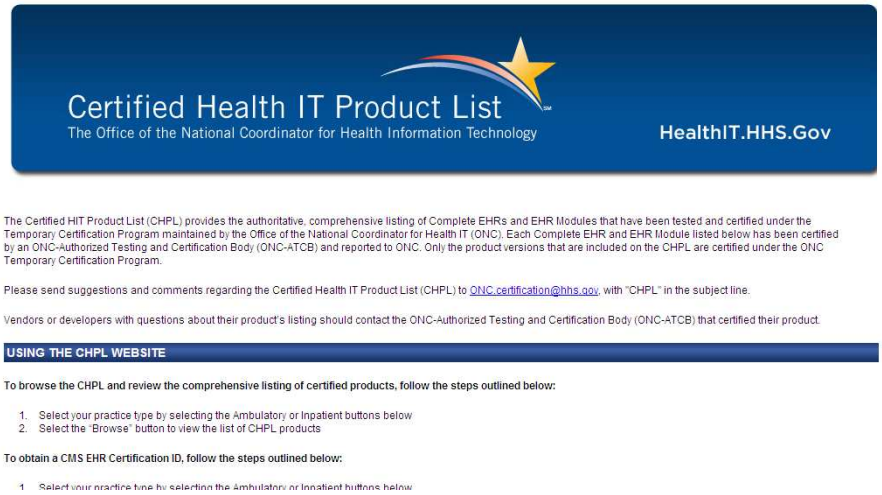
EHR Certification Page

This page allows you to identify your EHR Technology and attach supporting documentation. It appears for both AIU and MU

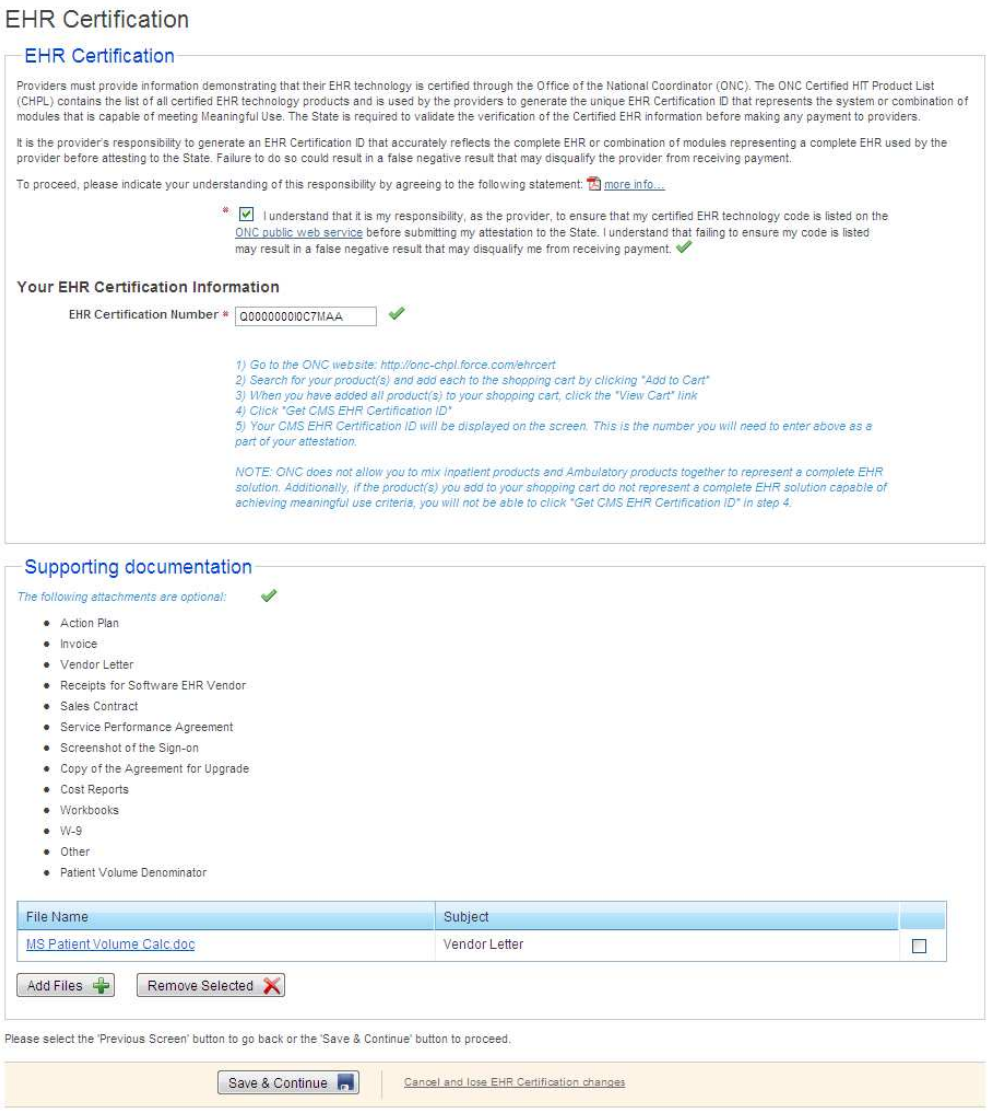
1. **Understanding** checkbox: signifies that you agree with the statement of understanding next to the checkbox. When you check this box, additional fields display. If you do not check this box, the system will not allow you to continue.

    a. "I understand that it is my responsibility, as the provider, to ensure…" This is a statement of understanding as to your responsibility to demonstrate that your EHR technology is certified through the ONC. When you check the box before this statement, you will be required to complete the other field on the page. If you do not check the box before this statement, the system will not allow you to continue.

    b. **ONC public web service** link: opens the Office of the National Coordinator for Health Information Technology's *Certified Health IT Product List* site. The page also includes instructions to access the ONC website, find software, and retrieve an EHR Certification Number (http://onc-chpl.force.com/ehrcert). Once this number is entered into the **EHR Certification Number** field and the **Save & Continue** button is clicked, SLR will validate that the number represents approved software.


Certified Health IT Product List
The Office of the National Coordinator for Health Information Technology
HealthIT.HHS.Gov
The Certified HIT Product List (CHPL) provides the authoritative, comprehensive listing of Complete EHRs and EHR Modules that have been tested and certified under the Temporary Certification Program maintained by the Office of the National Coordinator for Health IT (ONC). Each Complete EHR and EHR Module listed below has been certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) and reported to ONC. Only the product versions that are included on the CHPL are certified under the ONC Temporary Certification Program.
Please send suggestions and comments regarding the Certified Health IT Product List (CHPL) to ONC.certification@hhs.gov, with "CHPL" in the subject line.
Vendors or developers with questions about their product's listing should contact the ONC-Authorized Testing and Certification Body (ONC-ATCB) that certified their product.
USING THE CHPL WEBSITE
To browse the CHPL and review the comprehensive listing of certified products, follow the steps outlined below:
1. Select your practice type by selecting the Ambulatory or Inpatient buttons below
2. Select the "Browse" button to view the list of CHPL products
To obtain a CMS EHR Certification ID, follow the steps outlined below:
1. Select your practice type by selecting the Ambulatory or Inpatient buttons below

2. *Your EHR Certification Information* section. When you select the EHR Certification option in the *Navigation Menu* and are a member of a Group, the **CMS EHR Certification ID** field may already be populated, containing a certification number entered for the previous year's Attestation. Otherwise you will have to enter the correct number. If your hospital has changed its software since that time, look up and enter the correct number.


EHR Certification
EHR Certification
Providers must provide information demonstrating that their EHR technology is certified through the Office of the National Coordinator (ONC). The ONC Certified HIT Product List (CHPL) contains the list of all certified EHR technology products and is used by the providers to generate the unique EHR Certification ID that represents the system or combination of modules that is capable of meeting Meaningful Use. The State is required to validate the verification of the Certified EHR information before making any payment to providers.
It is the provider's responsibility to generate an EHR Certification ID that accurately reflects the complete EHR or combination of modules representing a complete EHR used by the provider before attesting to the State. Failure to do so could result in a false negative result that may disqualify the provider from receiving payment.
To proceed, please indicate your understanding of this responsibility by agreeing to the following statement: more info...
I understand that it is my responsibility, as the provider, to ensure that my certified EHR technology code is listed on the ONC public web service before submitting my attestation to the State. I understand that failing to ensure my code is listed may result in a false negative result that may disqualify me from receiving payment.
Your EHR Certification Information
EHR Certification Number *
Q0000000I0C7MAA
1) Go to the ONC website: http://onc-chpl.force.com/ehrcert
2) Search for your product(s) and add each to the shopping cart by clicking "Add to Cart"
3) When you have added all product(s) to your shopping cart, click the "View Cart" link
4) Click "Get CMS EHR Certification ID"
5) Your CMS EHR Certification ID will be displayed on the screen. This is the number you will need to enter above as a part of your attestation.
NOTE: ONC does not allow you to mix Inpatient products and Ambulatory products together to represent a complete EHR solution. Additionally, if the product(s) you add to your shopping cart do not represent a complete EHR solution capable of achieving meaningful use criteria, you will not be able to click "Get CMS EHR Certification ID" in step 4.
Supporting documentation
The following attachments are optional:
Action Plan
Invoice
Vendor Letter
Receipts for Software EHR Vendor
Sales Contract
Service Performance Agreement
Screenshot of the Sign-on
Copy of the Agreement for Upgrade
Cost Reports
Workbooks
W-9
Other
Patient Volume Denominator
File Name
Subject
MS Patient Volume Calc.doc
Vendor Letter
Add Files
Remove Selected
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.
Save & Continue
Cancel and lose EHR Certification changes

3. *Supporting Documentation* section: identical to the *Supporting Documentation* section on the *AIU Method* page. At least one document must be attached.

4. **Save & Continue** button: saves the information you have just entered. If you have left a required field blank or entered information incorrectly, you will receive an error message.

Once you have successfully saved the information on all pages within the AIU Attestation of EHR, the status icon on your home page will change to indicate that your Attestation of EHR section is complete. The system will now allow you move onto Step 4.

Meaningful Use Section

To attest for Meaningful Use (MU), Hospitals will enter data that has been captured by their EHR Software. A report within your EHR system should be available to help you enter the correct information in the MU fields. In the provider's second participation year, clicking the **3. Attestation of EHR** link shall open the *EHR Certification* page directly, as the user has the option to adopt, implement, or upgrade their software in the first year of participation only. Starting with the 2014 meaningful use reporting period all EHs and CAHs need to upgrade to 2014 Edition EHR technology – regardless of the meaningful use stage they need to meet.

Providers may elect to enter Meaningful Use data during their first year of Attestation, but are required to enter MU information during each year after their first year. The first year of MU is Stage 1, and fields are grouped into a series of Objectives and Clinical Quality Measures. Stage 2 of the Meaningful Use program begins in 2014, and this will require more fields to be populated and data to be captured. When providers attest for MU, they will enter the data captured by their software for a specified time period – 90 days for their first MU year, and a full year of data thereafter.

The 2014 Edition EHR certification criteria support both revised MU Stage 1 and new Stage 2 requirements. They also include important updates that set new baselines for better interoperability, electronic health information exchange, and patient engagement. EHR technology certified to the 2011 Edition will no longer be acceptable for the purposes of meeting the “Certified EHR Technology” definition and from a regulatory perspective 2011 Edition certifications will “expire” during the 2014 MU reporting period.

Attest To Meaningful Use
Eligible Hospitals attesting to Meaningful Use for the first time need to report Meaningful Use for a 90-day period within the federal fiscal year associated with the current payment (calendar) year. In this case, the earliest date an Eligible Hospital can submit an attestation for Meaningful Use for calendar year 2014 is January 1, 2014. Please return to the site on January 1, 2014 to complete your Meaningful Use attestation.
OK

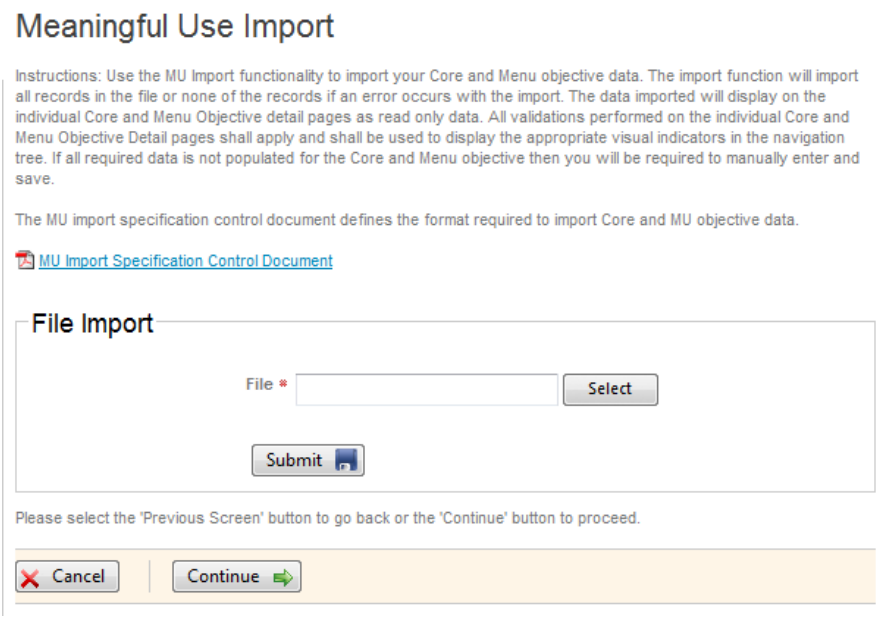
Note: In order to qualify for the EHR Incentive payment, 80% of patients must have records in the EHR solution.

In addition to pages that capture Meaningful Use information, there are two pages that capture information that is fundamental to Meaningful Use and for the Attestation for the EHR Incentive payment.

1. *EHR Certification* page. The *EHR Certification* page in the *Meaningful Use* section is identical to the *EHR Certification* page in the *AIU* section except that it also contains a *Supporting Documentation* section. This allows the user to attach a file if needed. Select the **Provider Understands Responsibility** checkbox to accept responsibility for finding and entering the correct EHR Certification Number into the previous page. A link to the Office of the National Coordinator for Health IT (ONC) website is provided.
2. *EHR Reporting Period* page. The 2014 MU reporting period for both Stage 1 and Stage 2 performance is set to any continuous 90-day or 3-month reporting period during 2013. All new EPs, EHs, and CAHs continue to have an “any continuous 90-day” reporting period.

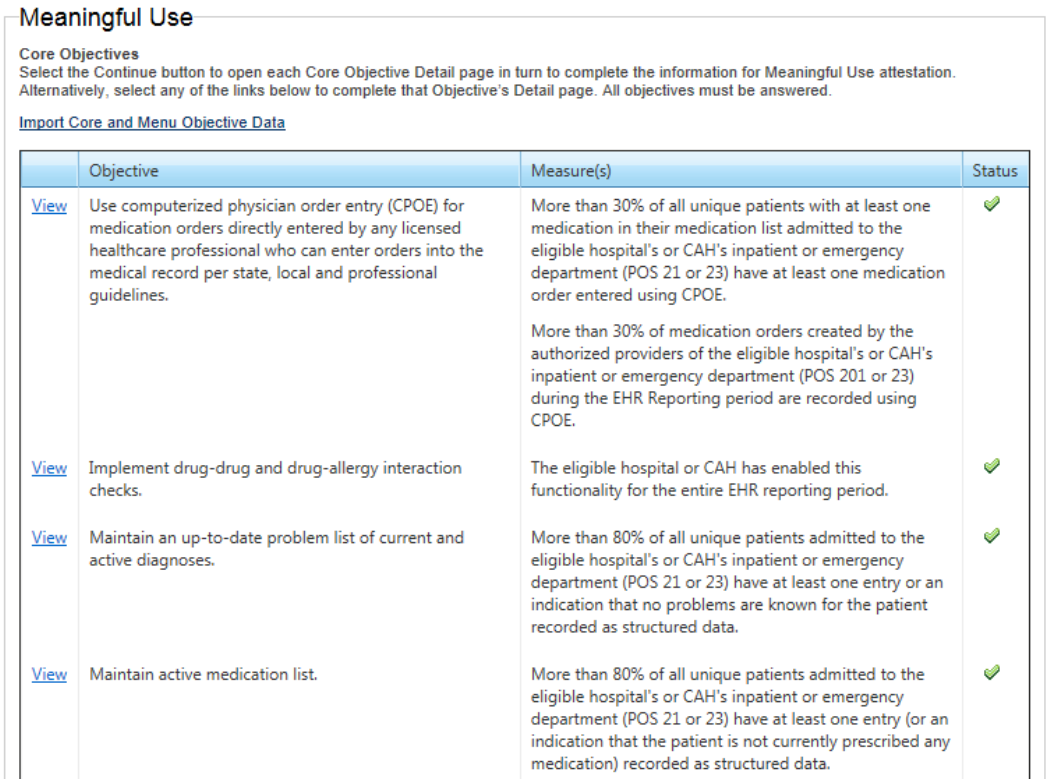
   This page contains a checkbox and **EHR Reporting Period** fields. The **Start Date** field and **End Date** fields have an icon that will open a Calendar Utility that allows a user to select a date rather than enter it into the field.
3. *Meaningful Use Import.* This page allows providers to import Core and Menu objective data. Data imported in this manner will display on the individual Core and Menu Objective detail pages as read only data. All validations performed on individual Core and Menu pages will be enforced and the appropriate visual indicators will be displayed in the navigation tree. Click the **MU Import Control Document** link to open technical specifications for the Import file.

Note: the import function will import all records in the file or none of the records if an error occurs with the import. If all required data is not populated for the Core and Menu objective then you will be required to manually enter and save.

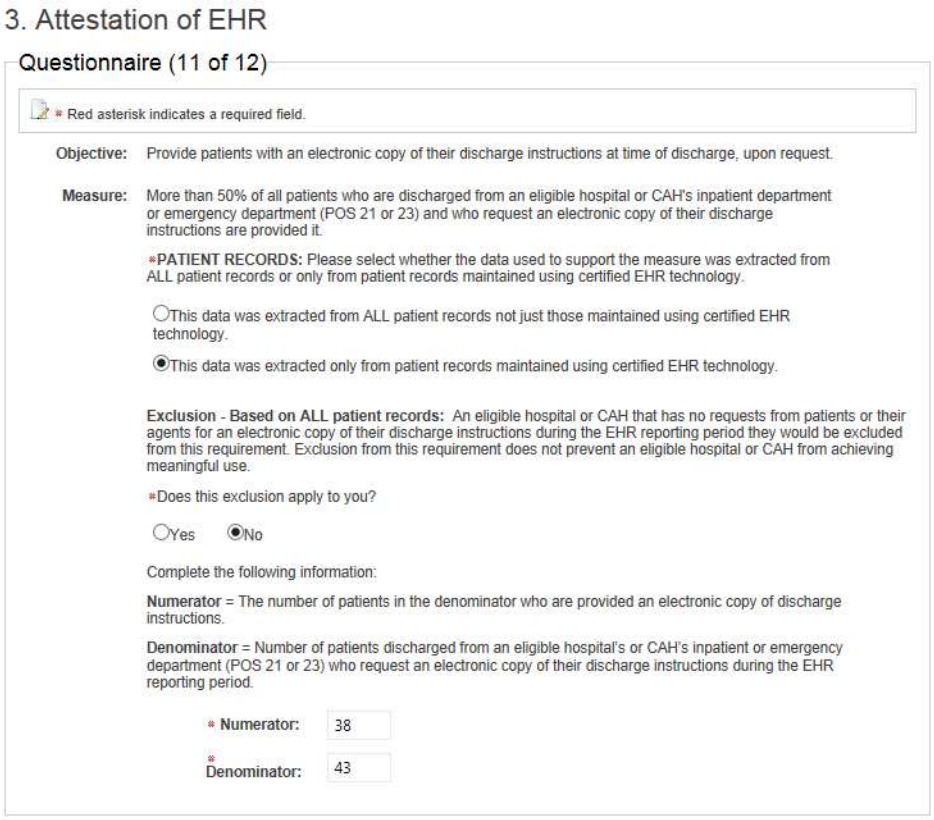

Meaningful Use Import
Instructions: Use the MU Import functionality to import your Core and Menu objective data. The import function will import all records in the file or none of the records if an error occurs with the import. The data imported will display on the individual Core and Menu Objective detail pages as read only data. All validations performed on the individual Core and Menu Objective Detail pages shall apply and shall be used to display the appropriate visual indicators in the navigation tree. If all required data is not populated for the Core and Menu objective then you will be required to manually enter and save.
The MU import specification control document defines the format required to import Core and MU objective data.
MU Import Specification Control Document
File Import
File *
Select
Submit
Please select the 'Previous Screen' button to go back or the 'Continue' button to proceed.
Cancel
Continue

4. *Stages*. Several Core and Menu objectives have been removed from or combined within the list of Stage 1 MU, and EHs will now need to provide more than 50% of unique patients with the ability to access their health information online. Several measures that were Core measures have become Menu Objectives for Stage 2. Measure exclusions can no longer be counted toward meeting Menu objectives. *Stage 2*. The list of measures is expanded for Stage 2, and the thresholds for passing the measure have increased for many of them.
5. *Navigation Menu.* The left-hand Navigation Menu will contain page titles that serve as links associated with the MU pages that must be completed. The majority of MU pages are collected in three groups. Clicking the name of a subgroup or clicking the expand icon ⊞ will reveal all the pages in the subgroup, all of which must be completed by the user. Once all the pages in a navigation group have been completed, and all have passed their validation criteria, then the group will receive a completed icon (✔). Clicking the collapse icon (⊟) will hide the title of the individual pages in a subgroup.
6. *Selection Pages and Detail Pages*. Each group of measures includes a *Selection* page, which provides a place for the user to select or at least access the measures. The *Menu Objective Selection* page allows a user to select Objective measures, since a user must select only some of the measures. Users cannot select a measure on the *Core CQM* or *Core Objective Selection* pages, since all core measures are required.

   Each measure within a group also includes a *Detail* page where users will record the applicable data. Select the **Save & Continue** button on each measure *Detail* page to save the data and move unto the next measure requiring input, or the next *Selection* page. All *Detail* pages include an *Attach Documentation* section so that users can associate a document that is relevant to the measure.


Meaningful Use
Core Objectives
Select the Continue button to open each Core Objective Detail page in turn to complete the information for Meaningful Use attestation. Alternatively, select any of the links below to complete that Objective's Detail page. All objectives must be answered.
Import Core and Menu Objective Data
Objective
Measure(s)
Status
View
Use computerized physician order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE.
More than 30% of medication orders created by the authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 201 or 23) during the EHR Reporting period are recorded using CPOE.
View
Implement drug-drug and drug-allergy interaction checks.
The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period.
View
Maintain an up-to-date problem list of current and active diagnoses.
More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.
View
Maintain active medication list.
More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

7. *Exclusions*. Sometimes the measure will not apply to your particular practice. Children's Hospitals, for example, will have no patients over 65 years old. To account for this, measures of this nature include Exclusion **Yes** and **No** radio buttons. The measure's data field will appear if the Exclusion does not apply.


3. Attestation of EHR
Questionnaire (11 of 12)
* Red asterisk indicates a required field.
Objective: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.
Measure: More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.
*PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
This data was extracted from ALL patient records not just those maintained using certified EHR technology.
This data was extracted only from patient records maintained using certified EHR technology.
Exclusion - Based on ALL patient records: An eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of their discharge instructions during the EHR reporting period they would be excluded from this requirement. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.
*Does this exclusion apply to you?
Yes
No
Complete the following information:
Numerator = The number of patients in the denominator who are provided an electronic copy of discharge instructions.
Denominator = Number of patients discharged from an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) who request an electronic copy of their discharge instructions during the EHR reporting period.
* Numerator: 38
* Denominator: 43

8. *Core Objectives*. Objectives measure how much of a provider's patient population has been entered into the EHR software for certain reasons. If the user selects the **Save & Continue** button with all fields completed on a page and the result fails the criteria set, a failed icon will appear. If even one Core Objective fails to meet its minimum criteria, the Attestation will fail.

   Providers must enter all Core Objectives and these are listed in the *Navigation Menu* when the MU Attestation Type is selected. Core Objectives generally consist of an acknowledgement that you have met the obligations, or a Numerator and a Denominator.

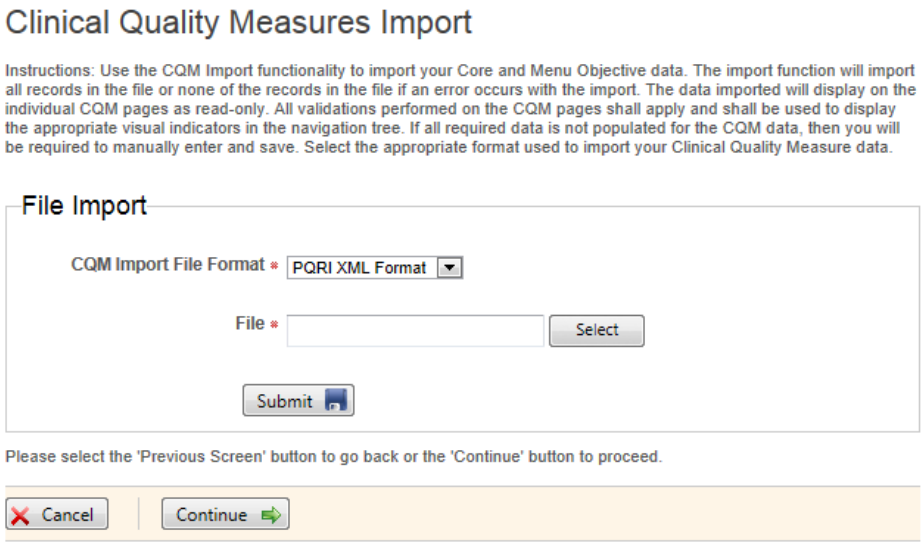
   For example, for the objective *Patient Clinical Summaries*, the user would enter the number of unique patients admitted to the Hospital's inpatient or emergency room that have at least one entry in their problem list, or an indication that no problems are known for the patient recorded as structured data. The Denominator would contain the number of unique patients seen during the EHR reporting period, and the Numerator would contain those that have entries in their problem list.

   Objectives also have a measure validation: if the result of the **Numerator** divided by the **Denominator** and rendered as a percentage does not exceed the percentage stated in the **Measure** field on each *Detail* page, the measure is failed. For example, *Patient Clinical Summaries* has a **Measure** of "More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data."

9. *Menu Objectives*. Users must select at least one of the Public Health Objectives on the *Menu Selection* page, and select a minimum of five of the Menu Objectives in general. When Menu Objectives are selected from the *Menu Selection* page, the selections will appear as options in the *Navigation Menu* when the **Save & Continue** button is selected on the page.

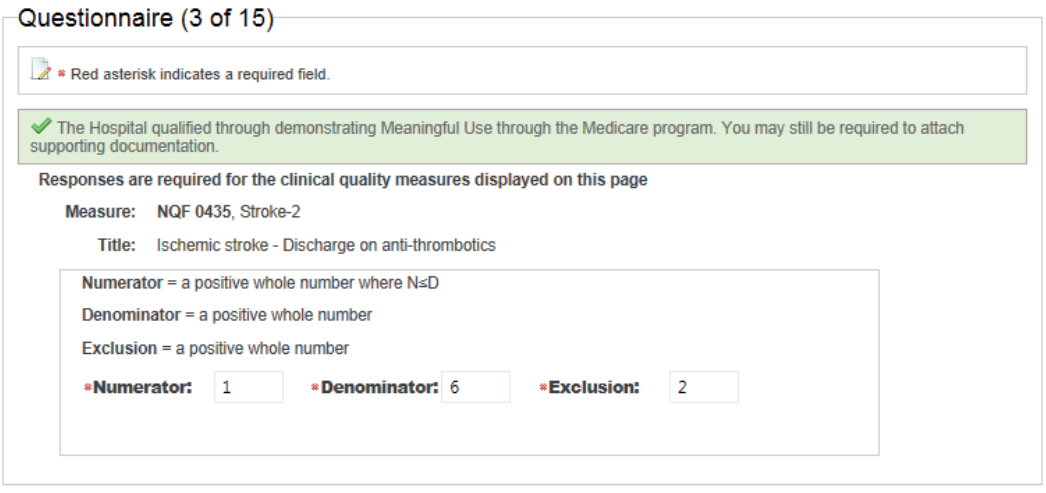
Other than being selected, Menu Objectives are similar in structure and content to the Core Objectives.

10. *Core Clinical Quality Measures* Import. This page allows providers to import CQM data in the same way the associated page allowed the import of Core and Menu objective data. Data imported in this manner will display on the individual CQM Detail pages as read only data. Validation performed on individual pages will be enforced and the appropriate visual indicators will be displayed in the navigation tree.


Clinical Quality Measures Import
Instructions: Use the CQM Import functionality to import your Core and Menu Objective data. The import function will import all records in the file or none of the records in the file if an error occurs with the import. The data imported will display on the individual CQM pages as read-only. All validations performed on the CQM pages shall apply and shall be used to display the appropriate visual indicators in the navigation tree. If all required data is not populated for the CQM data, then you will be required to manually enter and save. Select the appropriate format used to import your Clinical Quality Measure data.
File Import
CQM Import File Format *
PQRI XML Format
File *
Select
Submit
Please select the 'Previous Screen' button to go back or the 'Continue' button to proceed.
Cancel
Continue

11. *Core Clinical Quality Measures*. Clinical Quality Measures, or CQMs, capture information about patient treatments and diagnoses instead of information about the number of patients in the EHR. There are no passing percentages, as these pages are simply intended to capture information about patients.

    Core CQMs are all required. If the participating hospital has seen no patients to which one of these CQMs would apply, you will enter 0 in the **Denominator** field of that page's *Detail* page.


Questionnaire (3 of 15)
* Red asterisk indicates a required field.
The Hospital qualified through demonstrating Meaningful Use through the Medicare program. You may still be required to attach supporting documentation.
Responses are required for the clinical quality measures displayed on this page
Measure: NQF 0435, Stroke-2
Title: Ischemic stroke - Discharge on anti-thrombotics
Numerator = a positive whole number where N≤D
Denominator = a positive whole number
Exclusion = a positive whole number
*Numerator: 1
*Denominator: 6
*Exclusion: 2

12. *Dually Eligible Hospitals*. Some Hospitals, called Dually Eligible Hospitals, qualify for both Medicare and Medicaid incentive payments. Those hospitals that have already submitted and passed Meaningful Use measurements for Medicare automatically meet Meaningful Use obligations for the Medicaid program.

    CMS will send the SLR system a file called the C5, which will contain data that will automatically populate the SLR with the data entered into the Medicare EHR Incentive Program Registration and Attestation System. All pages will then be read-only for the SLR EH user.

As a dually-eligible hospital, you are required to submit your Medicare attestation data to CMS before submitting your Medicaid attestation. Your Medicare attestation data for program year 2014 has not been received from CMS. You may not submit any information for the program year, however, you may review previously submitted attestations.
If you have not previously submitted your Medicare attestation data, please log in to the CMS Registration & Attestation System (R&A) to complete your program year 2014 attestation.
If you have completed your Medicare attestation, please note that the attestation data is transmitted when CMS has approved the Medicare attestation. Attestation data is sent each night, so your data will be available no earlier than the business day after the approval of the Medicare attestation.
If you received confirmation of approval of your Medicare attestation from CMS several days ago and do not see your attestation data available in the SLR, please contact your State Medicaid Agency for assistance.
Close

    Clinical Quality Measures have been renumbered, as the NQF references are no longer used. The list of CQMs for Eligible Hospitals is in the table below.

eMeasure ID	Title	Description
CMS100	AM-2-Aspririn Prescribed at Discharge for AMI	Acute myocardial infarction (AMI) patients who are prescribed aspirin at hospital discharge.
CMS188	PN-6 Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients	Immunocompetent patients with Community-Acquired Pneumonia who receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines.
CMS53	AMI-8a- Primary PCI Received Within 90 Minutes of Hospital Arrival	Acute Myocardial Infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving primary PCI during the hospital stay with a time from hospital arrival of PCI of 90 minutes or less.
CMS60	AMI-7a- Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival	Acute Myocardial Infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the hospital stay with a time from hospital arrival of fibrinolysis of 30 minutes or less.
CMS26	Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver	An assessment that there is documentation in the medical record that a Home Management Plan of Care (KMPC) document was given to the pediatric asthma patient/caregiver.
CMS108	Venous Thromboembolism (VTE)01 VTE prophylaxis	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of

		or the day after hospital admission.
CMS190	VTE-2 Intensive Care Unit (ICU) VTE prophylaxis	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission or transfer.
CMS73	VTE-3 VTE Patients with Anticoagulation Overlap Therapy	This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications or have a reason for discontinuation of overlap therapy. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy, discharged on both medications or have a reason for discontinuation of overlap therapy.
CMS109	VTE-4 VTE Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram)	This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their plately counts monitored using defined parameters such as a nomogram or protocol.
CMS110	VTE-5 discharge instructions	This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, home care, court/law enforcement, or home on hospice care on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.
CMS114	VTE-6 Incidence of potentially preventable VTE	This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.
CMS104	Stroke-2 Ischemic Stroke – Discharged on anti-thrombotic therapy	Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge.
CMS71	Stroke-3 Ischemic Stroke – Anticoagulation Therapy for Atrial Fibrillation/Flutter	Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.
CMS91	Stroke-4 Ischemic Stroke – Thrombolytic Therapy	Acute ischemic stroke patients who arrive at this hospital within 2 hours (120 minutes) of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours (180 minutes) of time last known well.
CMS72	Stroke-5 Ischemic Stroke – antithrombotic therapy by	Ischemic stroke patients administered antithrombotic therapy by the end of hospital day

	end of hospital day two	two.
CMS105	Stroke-6 Ischemic Stroke – Discharged on Statin Medication	Ischemic stroke patients with LDL greater than or equal to 100 mg/dL, or LDL not measured, or, who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.
CMS107	Stroke-8 Ischemic or hemorrhagic stroke – Stroke education	Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.
CMS102	Stroke-10 Ischemic or hemorrhagic stroke – Assessed for Rehabilitation	Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.
CMS178	SCIP-INF-9 Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with day of surgery being day zero	Surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day zero
CMS113	PC-01 Elective Delivery Prior to 39 Completed Weeks Gestation	Patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed.
CMS9	Exclusive Breast Milk Feeding	Exclusive breast milk feeding during the newborn's entire hospitalization.
CMS55	Emergency Department (ED)-1 Emergency Department Throughput – Median time from ED arrival to ED departure for admitted ED patients	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.
CMS32	ED-3 Median time from ED arrival to ED departure for discharged ED patients	Median time from emergency department arrival to time of departure from the emergency from for patients discharged from the emergency department.
CMS111	ED-2 Emergency Department Throughput – admitted patients – Admit decision time to ED departure time for admitted patients	Median time from admit decision time to time of departure from the emergency room for patients admitted inpatient status.
CMS171	SCIP-INF-1 Prophylactic Antibiotic Received within 1 Hour Prior to Surgical Incision	Surgical patients with prophylactic antibiotics initiated within.one hour prior to surgical incision. Patients who received Vancomycin or a Fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within 2 hours prior to surgical incision. Due to the longer infusion time required for Vancomycin or a Fluorquinolone, it is acceptable to start these antibiotics within 2 hours prior to incision time.
CMS172	SCIP-INF-2 Prophylactic Antibiotic Selection for	Surgical patients who received prophylactic antibiotics consistent with current guidelines

	Surgical Patients	(specific to each type of surgical procedure).
CMS30	AMI-10 Statin Prescribed at Discharge	Acute Myocardial infarction (AMI) patients who are prescribed a statin at hospital discharge.
CMS185	Healthy Term Newborn	Percent of term singleton live births (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or in nursery care.
CMS31	EHDI-1a – Hearing screening prior to hospital discharge	This measure assesses the proportion of births that have been screened for hearing loss before hospital discharge.

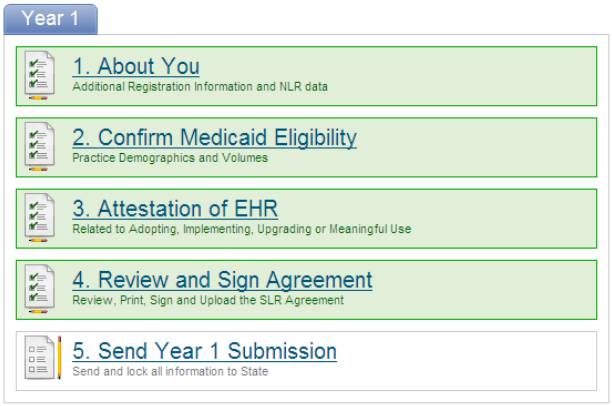
Step 4: Review and Sign Attestation

Clicking the **Review and Sign Attestation** link on the EH *Home* page directs you to *the 4. Review and Sign Agreement* page. This is where you will review the attestation agreement. Once you have had a chance to review it, you must print it out in order to sign it. Once signed, the agreement must be scanned and then uploaded into the SLR.

The *Review and Sign Attestation* page displays the following:

1. The *Step 1: Print to Sign Attestation* section contains the **Print to Sign** button. When selected, this will print a copy of the Attestation Agreement.
2. The *Step 2: Scan and Upload Signed Attestation* section contains an *Attach Documentation* component that will allow you to upload the Attestation Agreement. You have the ability to remove and attach different files until you submit your final attestation.
3. **Save & Continue** button: saves the information you have entered on this page and opens the *Home* page.
4. **Cancel and lose Review changes** link: clears the page of any information you have just entered and opens the *Home* page.

Once you have successfully saved the signed attestation, the status icon on your home page will change to indicate that Step 4 is complete. The system will now let you move onto Step 5.


Year 1
1. About You
Additional Registration Information and NLR data
2. Confirm Medicaid Eligibility
Practice Demographics and Volumes
3. Attestation of EHR
Related to Adopting, Implementing, Upgrading or Meaningful Use
4. Review and Sign Agreement
Review, Print, Sign and Upload the SLR Agreement
5. Send Year 1 Submission
Send and lock all information to State

Step 5: Send Year X Attestation Details

Clicking the **Send Year X Attestation** link opens a pop-up window allowing you to send your Hospital's attestation agreement to the State.

The *Send Attestation to State* window displays the following:

1. **Send Attestation** button: clicking this will submit your attestation agreement to the State. All steps in the workflow section of your home page will be locked down after this is done. You will not be able to make any more changes to the section, but can still view the information you entered on a report. The *Send Attestation to State* window will appear displaying the expected time period for payment and other payment-related information.
2. **Cancel and Do No Send** link: returns you to the *Home* page.

After sending the agreement, a System Message will arrive that designates the time and date.

Accessing Reports

Reports for Eligible Professionals

Located to the left of the page, the *Reports* section displays the following items:

1. Reports message: the following message appears if you don't have any data in the system to run a report: "Reports will be available once your information is saved."
2. **Registration and Attestation Summary Report** link: some information has been saved to the SLR web application, this link appears. Clicking this link opens a pop-up window with the **Registration and Attestation Summary** report results. This report prints all of the Attestation information that you have already entered.

   The **Registration and Attestation Summary** report displays the following:

   a. *Identifying Information* section: displays the information entered when the SLR account was created, including NPI, TIN, Phone Number, and Address.

   b. *Filing Information* section: displays the EHR Incentive application information, such as user type, program year, and payment year.

   c. *Contact Person* section: the name, phone number, and email of the EH's contact.

   d. *Confirmation of Eligibility* section: displays the information saved when you completed the *Confirmation of Eligibility* section.

   e. *Summary of Meaningful Use* sections: These three sections list your Hospital's Objective and Clinical Quality Measure data.

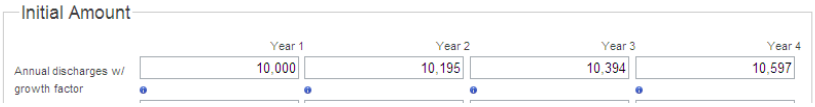
   You can print this report after you have saved any of your information in the SLR Web application. If you print the report before all of the areas have been completed, only those sections with saved information will print on the report. You can also filter the report by year.

Viewing Payment Information

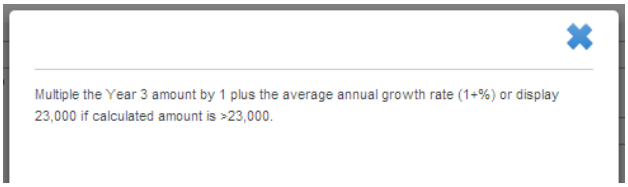
Payment Calculations for Eligible Hospitals

Located to the left of the page, the *Payment Information* section displays the following items that are visible on the home page:

1. **How your payment is calculated** link: opens a window that explains in detail how your payment is going to be calculated, including the per-discharge amount and the patient volumes entered for your Hospital.
    a. **< Back to Dashboard** link: returns you to the home page.
    b. *How Your Payment is Calculated* page.
    c. "States may pay hospitals up to 100 percent…" a detailed explanation as to how your payment will be paid.
    d. Information icons: click one of the small "i" icon to open a pop-up window containing information or instructions on the associated field.



Clicking the information icon beneath the Year 4 cell opens this help window:



    e. *Initial Amount* section.
        i. **Annual discharges w/growth factor** row: displays the discharges with growth factors applied to Year 2 through 4.
            1. Year 1: total discharges up to 23,000.
            2. Year 2: Year 1 amount plus the average annual growth rate (+1%) up to 23,000.
            3. Year 3: Year 2 amount plus the average annual growth rate (+1%) up to 23,000.
            4. Year 4: Year 3 amount plus the average annual growth rate (+1%) up to 23,000.
        ii. **Disallowed discharges** row: displays the discharges that are not allowed as part of the calculation.
            1. Metric: the per discharge amount is calculated based on the 1150th – 23,000th discharge.

2. Year 1: the disallowed discharges for year 1.
3. Year 2: the disallowed discharges for year 2.
4. Year 3: the disallowed discharges for year 3.
5. Year 4: the disallowed discharges for year 4.

iii. **Allowable discharges** row: displays discharges that are allowed as part of the calculation.

1. Metric: Year {X} Annual Discharges with growth factor – 1149, with a maximum of 23,000 allowable.
2. Year 1: the allowed discharges for year 1.
3. Year 2: the allowed discharges for year 2.
4. Year 3: the allowed discharges for year 3.
5. Year 4: the allowed discharges for year 4.

iv. **Per Discharge Amount** row: displays the amounts per discharge, currently $200 for all hospitals.

1. Metric: the per discharge amount is $200 for all hospitals.
2. Year 1: $200.
3. Year 2: $200.
4. Year 3: $200.
5. Year 4: $200.

v. **Discharge Related Amount** row: displays the amounts calculated on the allowable discharges.

1. Metric: Year {X} Allowable Discharges X Per Discharge, which is $200.
2. Year 1: the sum of allowed discharges for year 1 multiplied by $200.
3. Year 2: the sum of allowed discharges for year 2 multiplied by $200.
4. Year 3: the sum of allowed discharges for year 3 multiplied by $200.
5. Year 4: the sum of allowed discharges for year 4 multiplied by $200.

vi. **Base Amount** row: displays the base amount for all hospitals, which is $2,000,000.

1. Metric: the base amount is $2,000,000 for all hospitals.
2. Year 1: $2,000,000.
3. Year 2: $2,000,000.
4. Year 3: $2,000,000.
5. Year 4: $2,000,000.

vii. **Gross Amount** row: displays the sum of the base amount for all hospitals plus the discharge related amount.

1. Metric: Year {X} Discharge Related Amount plus Base Amount of $2,000,000.
2. Year 1: the gross amount for year 1.
3. Year 2: the gross amount for year 2.
4. Year 3: the gross amount for year 3.
5. Year 4: the gross amount for year 4.

viii. **Transition Factor** row: displays the transition factor applied for each year.

1. Metric: the transition factor is reduced each year.
2. Year 1: Displays the transition factor of 1.
3. Year 2: Displays the transition factor of 0.75.
4. Year 3: Displays the transition factor of 0.50.
5. Year 4: Displays the transition factor of 0.25.

ix. **Annual EHR Amount** row: displays the sum of the year's gross amount multiplied by the transition factor.

1. Metric: Year {X} Gross Amount X Transition Factor
2. Year 1: the annual EHR amount for year 1.
3. Year 2: the annual EHR amount for year 2.
4. Year 3: the annual EHR amount for year 3.
5. Year 4: the annual EHR amount for year 4.

x. **Overall EHR Amount** row: displays the sum your EHR amounts for all four years.

f. *Medicaid Share* section.

i. **Medicaid Inpatient Bed Days** field: displays the Medicaid inpatient bed days that entered on the *Confirm Eligibility* page.

ii. **Medicaid Managed Care Inpatient Bed Days** field: displays the Medicaid Managed Care inpatient bed days that entered on the *Confirm Eligibility* page.

iii. **Numerator** field: displays the sum of the two previous fields: *Medicaid Inpatient Bed Days + Medicaid Managed Care Inpatient Days.*

iv. **Total Inpatient Bed Days** field: displays the inpatient bed days that you entered on the *Confirm Eligibility* page.

v. **Total Charges** field: displays the total charges you entered on the Confirm Eligibility page.

vi. **Total Charity Care Charges** field: displays the total charges that you attributed to charity care on the *Confirm Eligibility* page.

vii. **Denominator** field: displays the results of *Total Inpatient Bed Days x ((Total Charges - Total Charity Care Charges) / Total Charges.*

viii. **Medicaid Share** field: displays the results of *(Medicaid Inpatient Bed Days + Medicaid Managed Care Inpatient Bed Days) / (Total Inpatient Bed Days x ((Total Charges - Total Charity Care Charges) / Total Charges)).*

g. *Aggregate EHR Amount* section.

The Aggregate EHR amount is the Overall EHR Amount x Medicaid Share. If a Recoupment or Adjustment has been made to this Payment Year's Attestation, that information will be reflected here as well.

Appeals, Adjustments and Recoupments

Appeals

EH Providers are able to appeal a rejection of their Attestation or other decisions made by the State. The rules and details are specified by the State of Montana, and will follow guidelines established by CMS. All communications and the progression of each Appeal will be handled by State representatives.

Adjustments

An Adjustment in SLR is an official change in the payment amount of a provider's EHR Incentive payment. Hospitals will likely have several adjustments. Each time a Hospital's final payment is changed, several of the Payment Years are likely to change. For example, a 2012 Cost Report establishes the payment that will be made to a Hospital. The 2013 Cost Report causes the provider to submit revised data, and this changes the overall payment amount.

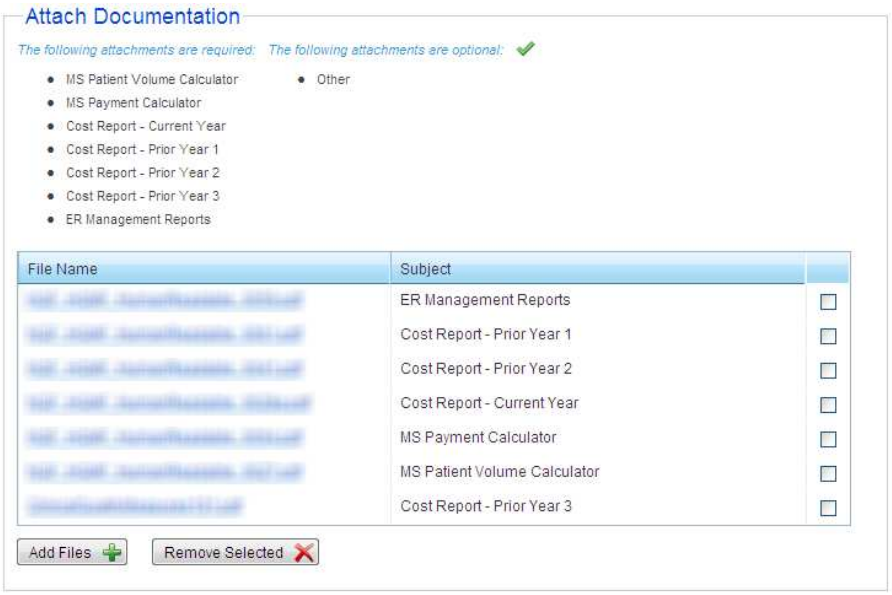
Recoupments

A Recoupment is a return to the State of the full amount paid to the provider for a Payment Year. This will usually be the result of Audit showing a mistake in the Medicaid claims percentage. As with Appeals and Adjustments, State representatives will handle the communication with providers regarding all Recoupments.

Attaching Files

The Attach Documentation Section

Attach Documentation sections are available in several pages of the SLR. These identify documents that must be attached – like a Cost Report, a fully executed software sales contract, a vendor letter, and the Attestation Agreement itself – and identify documents that are optional.



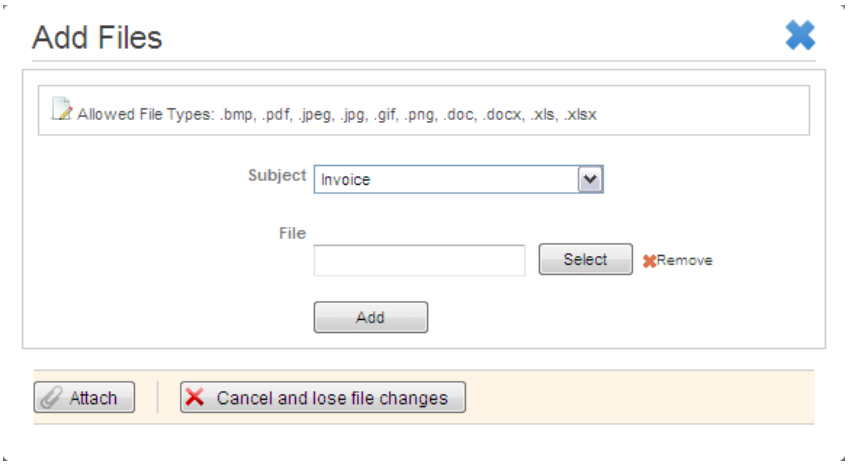
A table lists those attachments that have already been added to the section in three columns:

1. **Filename** column: the name of the uploaded file. Selecting the filename will open the file for viewing, provided your PC has an application that can open the file.
2. **Subject** column: the subject of the uploaded file selected by the user when the file was attached.
3. Selecting a checkbox in the unnamed column and clicking the **Remove Selected** button will remove the file from the list and delete the file from SLR.

Clicking the **Add Files** button opens the *Add Files* pop-up window.

1. Close icon: clicking the blue X in the upper right-hand corner closes the *Add Files* window without attaching a file.
2. **Subject** pull-down menu: select an option to identify what type of document or documents you are attaching. These will be restricted to subjects that are appropriate for the section of SLR you are viewing.
3. **File** text field: the file name will display once it is selected.
4. **Select** button: allows you to select the file you would like to attach from a local drive.
5. **Add** button: adds another **File** field and Select button to allow the user to attach another file. The file will be added under the same subject as the file above it.
6. **Remove** icon: clicking this removes file reference from the window. It will not be imported.
7. **Attach** button: adds the document or documents that were selected.
8. **File(s) Attached – {X}** message allows you to know the number of files currently attached for this specific page.

Up to 10 files of up to 10 MB apiece can be added to the *Attach Documentation* component of each section.



Timing Out

SLR pages have a session timeout occur at 9 minutes and 30 seconds. If no field has been modified or a page accessed during that time, a pop-up window shall appear asking if you wish to log out or continue to use SLR. The pop-up window itself will disappear in 30 seconds if no action is taken.

Troubleshooting

Accessing Help

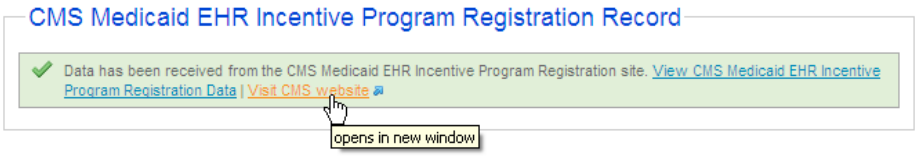
For general Help, all SLR web pages have a **Help** Link that opens up a copy of this User Manual. For SLR Web application assistance, you can contact the ACS Help Desk designated to support the SLR.

Phone: (866) 879-0109
Email: SLRHelpdesk@acs-inc.com

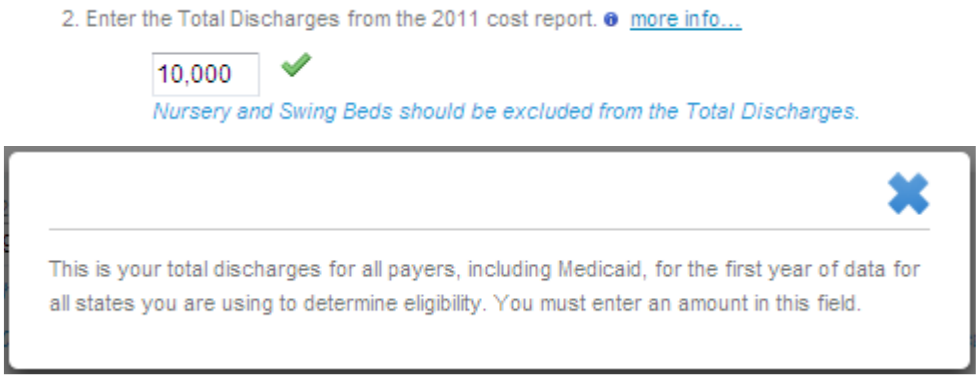
Help Text Displays

Located throughout the SLR Web application, there are tool tips, help text, and **more info** links that should help to complete the pages.

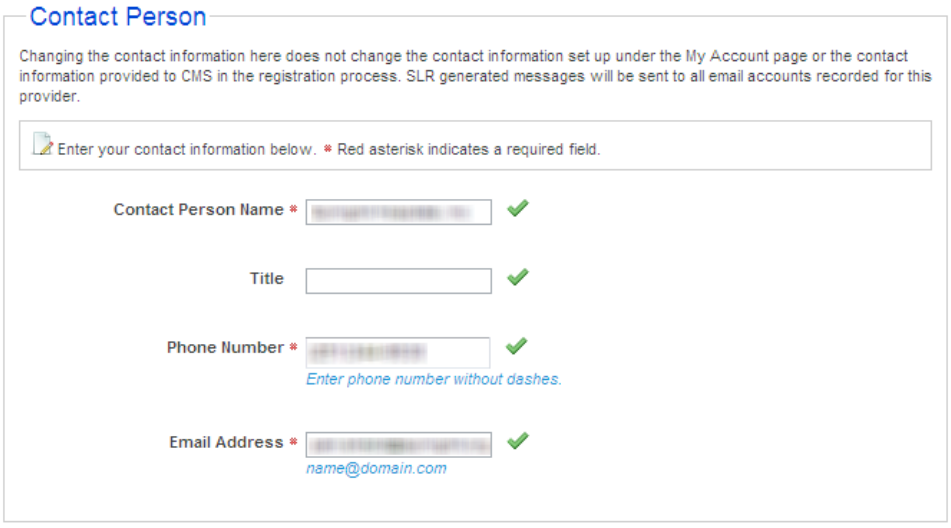
1. Tool Tips: A tool tip is text that displays when you hover your mouse over an area on the page.


CMS Medicaid EHR Incentive Program Registration Record
Data has been received from the CMS Medicaid EHR Incentive Program Registration site. View CMS Medicaid EHR Incentive Program Registration Data | Visit CMS website
opens in new window

2. The **more info** link of this field opens the following help window:


2. Enter the Total Discharges from the 2011 cost report. more info...
10,000
Nursery and Swing Beds should be excluded from the Total Discharges.
This is your total discharges for all payers, including Medicaid, for the first year of data for all states you are using to determine eligibility. You must enter an amount in this field.

3. Help Text. Help text is text that displays on the page. Help text instructs you on how to respond to a particular field or, it provides some additional information about the field or the page. The blue text from the below example, “Enter phone number without dashes.” This is help text.


Contact Person
Changing the contact information here does not change the contact information set up under the My Account page or the contact information provided to CMS in the registration process. SLR generated messages will be sent to all email accounts recorded for this provider.
Enter your contact information below. * Red asterisk indicates a required field.
Contact Person Name *
Title
Phone Number *
Enter phone number without dashes.
Email Address *
name@domain.com

Definitions

This section lists any glossary terms specifically applicable to this document.

Term/Acronym	Explanation/Expansion
Active Medication List	A list of medications that a given patient is currently taking.
Adjustment	An official change in the payment amount of a provider's EHR Incentive payment. This can be a positive or negative change.
Admitted to the Emergency Department	There are two methods for calculating ED admissions for the denominators for measures associated with Stage 1 of Meaningful Use objectives. Eligible hospitals and CAHs must select one of the methods below for calculating ED admissions to be applied consistently to all denominators for the measures. That is, eligible hospitals and CAHs must choose either the "Observation Services method" or the "All ED Visits method" to be used with all measures. Providers cannot calculate the denominator of some measures using the "Observation Services method," while using the "All ED Visits method" for the denominator of other measures. Before attesting, eligible hospitals and CAHs will have to indicate which method they used in the calculation of denominators. [3]
All ED Visits Method	An alternate method for computing admissions to the ED is to include all ED visits (POS 23 only) in the denominator for all measures requiring inclusion of ED admissions. All actions taken in the inpatient or emergency departments (POS 21 and 23) of the hospital would count for purposes of determining meaningful use. [3]
Allergy	An exaggerated immune response or reaction to substances that are generally not harmful. Unique Patient – If a patient is seen by a provider more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term ''unique patient'' relate to what is contained in the patient's medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period. [3]
American Reinvestment and Recovery Act of 2009 (ARRA)	The American Reinvestment and Recovery Act of 2009 is an economic stimulus package enacted by the 111th United States Congress in February 2009[1]. Part of the act included money for health information technology (HIT) investments and payments.

[1] "American Recovery and Reinvestment Act of 2009." *Wikipedia: The Free Encyclopedia* Wikimedia Foundation, Inc. Last modified: November 18, 2010. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
Appeal	A petition by a provider to change a decision made by a State user or Auditor. The rules and details follow guidelines established by CMS and are enforced at the State level.
Appropriate Technical Capabilities	A technical capability would be appropriate if it protected the electronic health information created or maintained by the certified EHR technology. All of these capabilities could be part of the certified EHR technology or outside systems and programs that support the privacy and security of certified EHR technology. [3]
Business Days	Business days are defined as Monday through Friday excluding Federal or State holidays on which the EH or their respective administrative staffs are unavailable. [3]
Centers for Medicare and Medicaid Services (CMS)	The Centers for Medicare and Medicaid Services (CMS) is a United States Federal Agency which administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[2]
Clinical Decision Support	HIT functionality that builds upon the foundation of an EHR to provide persons involved in care decisions with general and person-specific information, intelligently filtered and organized, at point of care, to enhance health and health care. [3]
Clinical Summary	An after-visit summary that provides a patient with relevant and actionable information and instructions containing the patient name, provider's office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.[3]
CMS Certification Number (CCN)	A number assigned to hospitals by the Centers of Medicare and Medicaid Services, the CMS Certification Number (CCN) is the hospital's identification number that is link to its Medicare provider agreement. The CCN is used for CMS certification and also for submitted and reviewing the hospital's cost reports.[4]

[2] "Centers for Medicare & Medicaid Services." *CMS: Centers for Medicare & Medicaid services.* United States Department of Health & Human Services. Date accessed: November 22, 2010.
[3] "HITECH Attestation Mockups EP" and "HITECH Attestation Mockups EH Version 9". CMS: Centers for Medicare & Medicaid services. United States Department of Health & Human Services. Date published: 3/8/2011.
[4] "Frequently Asked Questions about Accrediting Hospitals in Accordance with their CMS' Certification Number (CCN)." *The Joint Commission*. Article date: July 15, 2010. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
CMS Medicaid EHR Incentive Program Registration site	The national d that supports the administration and incentive payment disbursements of Medicare and Medicaid programs to medical professionals, hospitals and other organizations.[5]
Computerized Physician Order Entry (CPOE)	Computerized Physician Order Entry (CPOE) refers to any system in which clinicians directly enter medication orders and/or tests and procedures into a computer system, which then transmits the order directly to the pharmacy.[6]
Computerized Provider Order Entry (CPOE)	CPOE entails the provider's use of computer assistance to directly enter medication orders from a computer or mobile device. The order is also documented or captured in a digital, structured, and computable format for use in improving safety and organization. [3]
CPOE	See Computerized Provider Order Entry. [3]
Diagnostic Test Results	All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests. [3]
Different Legal Entities	A separate legal entity is an entity that has its own separate legal existence. Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned or controlled by the other. [3]
Discharge Instructions	Any directions that the patient must follow after discharge to attend to any residual conditions that need to be addressed personally by the patient, home care attendants, and other clinicians on an outpatient basis. [3]
Distinct Certified EHR Technology	Each instance of certified EHR technology must be able to be certified and operate independently from all the others in order to be distinct. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct. [3]
EHR Provider Incentive Portal (SLR)	The EHR Provider Incentive Portal (SLR) is a Xerox application created for the capture and maintenance of state mandated information related to the payment of Provider incentive payments provided for under the ARRA.

[5] "Grumman nets $34M CMS' data repository project." *CMIO Contracts and Installations*. TriMed Media Group, Inc. Article date: May 17, 2010. Data accessed: November 22, 2010.

[6] "Computerized Provider Order Entry." AHRQ: Agency for Healthcare Research and Quality. United States Department of Health & Human Services. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
Electronic Health Record (EHR)	An Electronic Health Record (EHR) is an electronic version of a patients medical history, that is maintained by the Provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular Provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports.[7]
Electronic Medical Record (EMR)	An electronic medical record (EMR) is a computerized medical record created in an organization that delivers care, such as a hospital and doctor's surgery.[8]
Eligible Hospital (EH)	For the purposes of the Medicaid EHR Incentive Program and SLR applications documentation, an eligible hospital (EH) is defined as the following: Acute care hospitals (including Critical Access Hospitals and cancer hospitals) with at least 10% Medicaid patient volume. Children's hospitals (no Medicaid patient volume requirements).[9]
Eligible Professional (EP)	For the purposes of the Medicaid EHR Incentive Program and SLR application documentation, an eligible professional (EP) is defined as the following: Physicians (primarily doctors of medicine and doctors of osteopathy). Nurse practitioner. Certified nurse-midwife. Dentist. Physician assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant. To qualify for an incentive payment under the Medicaid EHR Incentive Program, an EP must meet one of the following criteria: Have a minimum 30% Medicaid patient volume*. Have a minimum 20% Medicaid patient volume, and is a pediatrician*. Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals. *Children's Health Insurance Program (CHIP) patients do not count toward the Medicaid patient volume criteria.[10]

[7] "Electronic Health Records Overview." *CMS: Centers for Medicare & Medicaid services.* United States Department of Health & Human Services. Date accessed: November 22, 2010.
[8] "Electronic medical record." *Wikipedia: The Free Encyclopedia* Wikimedia Foundation, Inc. Last modified: November 5, 2010. Date accessed: November 22, 2010.
[9] "EHR Incentive Programs: Eligibility – Eligible Hospitals." *CMS: Centers for Medicare & Medicaid services.* United States Department of Health & Human Services. Date accessed: November 22, 2010.
[10] "EHR Incentive Programs: Eligibility – Eligible Professionals." *United States Department of Health & Human Services*. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
End User License Agreement (EULA)	The End User License Agreement (EULA) details how the software can and cannot be used.[11]
Exchange	Clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR technologies. The exchange of information requires that the provider must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or other vendor-specific alternative methods for exchanging clinical information. Electronic Exchange of Clinical Information. [3]
Federally Qualified Health Center (FQHC)	A type of provider that includes all organizations receiving grants under Section 330 of the Public Health Service Act. Advantages include grant funding, enhanced Medicare and Medicaid reimbursement, medical malpractice coverage through the Federal Tort Claims Act, reduced cost for medications for outpatients, etc.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	The purpose of the Health Insurance Portability and Accountability Act is "to improve…the Medicaid program…and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information."[12]
Health Information Technology (HIT)	Health Information Technology (HIT) refers to the use of technology in managing health information. For example, the use of electronic health records instead of paper medical records.
Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH)	The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) amends the Public Health Service Act by adding a number of funding opportunities to advance health information technology.[13]
Medication Reconciliation	The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. [3]
National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care Providers.[14]

[11] "EULA." *Webopedia*. QuinStreet Inc. Date accessed: November 22, 2010.
[12] "Health Insurance Portability and Accountability Act of 1996." *CMS: Centers for Medicare & Medicaid services.* Public Law 104-191. 104th Congress. Date accessed: November 22, 2010.
[13] "HITECH and Funding Opportunities." *The Office of the National Coordinator for Health Information Technology*. United States Department of Health & Human Services. Date accessed: November 22, 2010.
[14] "National Provider Identifier Standard (NPI): Overview." *CMS: Centers for Medicare & Medicaid services.* United States Department of Health & Human Services. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
Observation Services Method	"The denominator should include the following visits to the ED: • The patient is admitted to the inpatient setting (place of service (POS) 21) through the ED. In this situation, the orders entered in the ED using certified EHR technology would count for purposes of determining the computerized provider order entry (CPOE) Meaningful Use measure. Similarly, other actions taken within the ED would count for purposes of determining Meaningful Use • The patient initially presented to the ED and is treated in the ED's observation unit or otherwise receives observation services. Patients who receive observation services under both POS 22 and POS 23 should be included in the denominator." [3]
Office of the National Coordinator (ONC) for Health Information Technology	The Office of the National Coordinator for Health Information Technology (ONC) is the principal Federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information.[15]
Office Visit	Office visits include separate, billable encounters that result from evaluation and management services provided to the patient and include: (1) Concurrent care or transfer of care visits, (2) Consultant visits, or (3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider. [3]
Patient Authorized Entities	Any individual or organization to which the patient has granted access to their clinical information. Examples would include an insurance company that covers the patient, an entity facilitating health information exchange among providers, or a personal health record vendor identified by the patient. A patient would have to affirmatively grant access to these entities. [3]
Patient-Specific Education Resources	Resources identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient. [3]
Permissible Prescriptions	The concept of only permissible prescriptions refers to the current restrictions established by the Department of Justice on electronic prescribing for controlled substances in Schedule II-V. (The substances in Schedule II-V can be found at http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf). Any prescription not subject to these restrictions would be permissible. [3]
Preferred Language	The language by which the patient prefers to communicate. [3]
Prescription	The authorization by a provider to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization. [3]

[15] "The Office of the National Coordinator for Health Information Technology (ONC)." *The Office of the National Coordinator for Health Information Technology*. United States Department of Health & Human Services. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
Problem List	A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient. [3]
Provider	For the purposes of the EHR Provider Incentive Portal (SLR) application documentation, a Provider refers to both EPs and EHs.
Public Health Agency	An entity under the jurisdiction of the U.S. Department of Health and Human Services, tribal organization, State level and/or city/county level administration that serves a public health function. [3]
Recoupments	A Recoupment is a return to the State of the full amount paid to the provider for a Payment Year.
Relevant Encounter	An encounter during which the provider performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons determined appropriate by the provider . Essentially an encounter is relevant if the provider judges it to be so. (Note: Relevant encounters are not included in the numerator and denominator of the measure for this objective.) [3]
Rural Health Clinic (RHC)	RHCs must be located in rural, underserved areas and must use one or more physician assistants or nurse practitioners. RHCs can be public, private, or non-profit, and are intended to increase primary care services for Medicaid and Medicare patients in rural communities. An advantage of RHC status is enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas.
Specific Conditions	Those conditions listed in the active patient problem list. [3]
State Level Registry (SLR)	The State Level Registry (SLR) is a Xerox application created for the capture and maintenance of state mandated information related to the payment of provider incentive payments provided for under the ARRA.
Taxpayer Identification Number (TIN)	A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws.[16]
Transition of Care	The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another. [3]
Uniform Resource Locator (URL)	In computing, a Uniform Resource Locator (URL) is a Uniform Resource Identifier (URI) that specifies where an identified resource is available and the mechanism for retrieving it.[17]

[16] "Taxpayer Identification Numbers (TIN)." IRS.gov. Internal Revenue Service. Last modified: August 20, 2010. Date accessed: November 22, 2010.

[17] "Uniform Resource Locator." *Wikipedia: The Free Encyclopedia* Wikimedia Foundation, Inc. Last modified: November 22, 2010. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
Unique Patient	If a patient is seen by a provider more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term ‘‘unique patient’’ relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.[3]
Up-to-date	The term ‘‘up-to-date’’ means the list is populated with the most recent diagnosis known by the provider . This knowledge could be ascertained from previous records, transfer of information from other providers, diagnosis by the provider, or querying the patient. [3]